Mental Health System Transformation Initiative Implementation

Washington State
Department of Social & Health Services

STI Task Force Meeting

June 21, 2007

Agenda

1. External Utilization Management Project (Harborview)
2. Housing Action Plan (Common Ground)
3. Mental Health Benefits Package (TriWest)
4. Involuntary Treatment Act Study (AHP)
5. Wrap up and next steps

HARBORVIEW MEDICAL CENTER
UW Medicine

Center for Healthcare Improvement For Addictions, Mental Illness And Medically Vulnerable Populations
"Research & Training to Improve Clinical Care"

Washington Inpatient Utilization Management Project

Report to Systems Transformation Initiative Task Force June 21, 2007

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Overview of Project Purpose

- To review process and practice of UM/UR in community and state hospitals by RSN and MHD.
  - Medicaid and ITA covered individuals served in community hospitals.
  - All individuals served by state hospitals.
- Compare and analyze practice across the RSNs and state hospitals.
- Develop options and recommendations for improvements.

Project Methods and Activities

- Review UM practice in Washington State
- Review current UM practices at state hospitals
- Conduct stakeholder interviews/surveys
- Peer state analysis
- MHD data analysis
- Review acuity measures and UM/UR tools

Definitions and Principles

Definitions:

Utilization Management (UM): The standards and procedures used to ensure appropriate use of publicly funded mental health resources statewide. Focus is on the system.

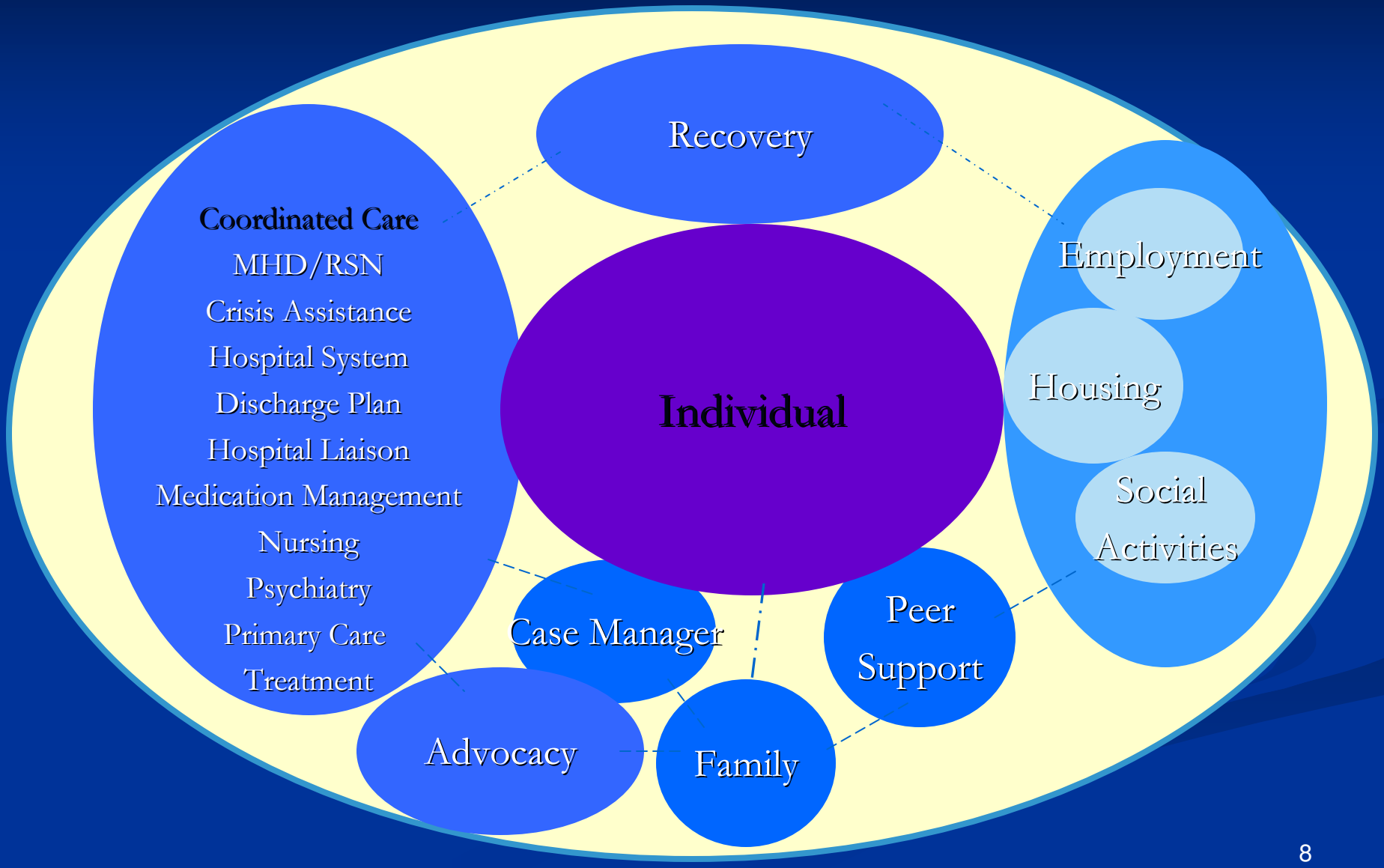
Utilization Review (UR): The standards and procedures used to assess the quality of the services received by an individual and the medical necessity of such services. Focus is on the individual.

Quality of care is as important as cost containment

Giving the right service, in the right place, for the right amount of time.

Current System -- Islands of Disconnect

Quality of Care Means That the Individual Is the Center of Services and Support



Guiding Principles

Governor Gregoire's 2006 directives to state agencies purchasing health care services identified in Washington Mental Health Transformation Plan: Phase I

- Emphasis on evidence-based health care
- Better management of chronic illness
- More transparency in health systems
- Better use of health information technologies
- Promotion of prevention, healthy lifestyles, and healthy choices

Recommendation # 1

- Establish a statewide standardized UM protocol for pre-authorization and length of stay criteria.
- This would be done by using an instrument that has been scientifically tested and proven to be reliable and valid.

Rationale for Standardization

- Standardized approaches to delivering individualized care assures, reliable, consistent outcomes, improving the safety and quality of care.
- Standardized approaches to delivery of care produces better outcomes in the management of chronic illnesses, a guiding principle of this project and meets the expectations of Governor Gregoire's 2006 health care mandates.
- Individuals need to be served in the appropriate level of care based upon known standards.
- Standardized approaches to delivery of care increases system transparency, a guiding principle of this project and another 2006 health care mandate.
- Instruments that have been scientifically tested for reliability and validity and have outcome data available for public review represent best practice, another project principle and 2006 health care mandate.

Project Findings Supporting Recommendation # 1

- Community hospital survey respondents express frustration with inconsistencies in procedures for admission pre-authorization and concurrent review among RSN UM representatives.
- A review of RSN standards and procedures reflect a lack of consistency in carrying out UM functions and in tools used to conduct UM/UR.
- Practices for UM/UR are not standardized across state hospitals.

More Project Findings Supporting Recommendation # 1

- There is no common language used across community hospitals, RSN UM representatives, and state hospitals for understanding individual consumer's medical or behavioral acuity. This creates barriers to system transparency.

- Respondents reported GAF scores and diagnostic labels are insufficient methods for understanding an acute episode of illness. These are commonly used in an attempt to facilitate communication between systems.

- Representatives from community hospitals, some RSN administrators and RSN UM representatives expressed the need and desire to use a reliable and valid scale/instrument for UM/UR functions.

Discussion of Recommendation #1

Statewide standardization of process and procedures facilitated by the use of a reliable and valid UM/UR instrument.

Recommendation # 2

- Whatever instrument is selected, it is essential that the generated raw data be made available to the MHD for analysis and review.

- The data system Provider One should be reviewed to see if standardized raw data points can be collected and reported through this system.

Project Findings Supporting Recommendation # 2

- Analysis of administrative data indicates a subset of individuals have unusually long stays at state hospitals. More standardized data about them (such as medical/behavioral acuity) would allow for improved management.

- Analysis of administrative data indicates that 27% of discharges from state hospitals are re-admitted within one year of discharge. Some of these individuals were admitted two or more times. Closer tracking of re-admissions could lead to improved UM.

- Multiple stakeholders report having questions and concerns that can be addressed by data analysis on a statewide basis.

Discussion of Recommendation # 2

Report raw data to MHD

Consider using Provider One

Recommendation # 3

Statewide medical expertise is essential to a successful UM/UR program. We recommend the MHD hire a Director of Inpatient Care Management or a Chief Medical Officer well versed in public behavioral health care management.

Project Findings Supporting Recommendation # 3

- Our review of documents and interviews indicates that managed care is in various stages of maturity at all system levels throughout the state. Leadership can promote needed collaborative and strategic development.
- A number of RSN administrators request leadership/assistance from the MHD in identifying useful behavioral health tools for improvement of UM/UR processes.
- Other comparison states reviewed for this report support this type of position.

More Project Findings Supporting Recommendation # 3

- Dispute resolution between system entities is inadequate. Three examples illustrate the problem.

  1. RSNs report that state hospital treatment teams sometimes disagree with discharge options developed by the RSNs, blocking or slowing appropriate discharges.

  2. State hospital staff report that some RSNs object to a discharge or refuse to transfer a patient into their RSN.

  3. Community hospitals report that if a patient is ready to leave the inpatient setting but there is not an adequate discharge option provided by the RSN, their payment is reduced even if they are not responsible for the delay.

Discussion of Recommendation #3

Hiring of Behavioral Health Care Management Expert on MHD staff

Recommendation # 4

Review of each RSNs diversion and discharge resources should be conducted in order to forecast needed areas of development. The 2002, 2004, and 2005 PCG studies are still relevant and can be used as an immediate source of identified needs.

Project Findings Supporting Recommendation # 4

- Many RSN administrators report effective UM/UR will continue to be challenged regardless of the adopted models or tools, given the number of community-based resource gaps.

- There is widespread agreement by RSN administrators, community hospital representatives, and state hospital staff that there are serious gaps in discharge options especially for specialized populations (i.e., DD, TBI, dementia, physically ill, and persons with history of arson or assault). This problem extends LOS.

More Project Findings Supporting Recommendation # 4

- Respondents consistently reported that because of the wide net cast by RCW 71.05, there are many individuals in state and community hospitals that do not meet access to care criteria for outpatient care. Allied systems (e.g., DDD, DASA, Home and Community Services), by and large, do not contribute to the development of outpatient options for these consumers, nor share in the financial risk.

- Discharge barriers occur at all levels of the system: lack of placements for specialized populations, lack of structured residential placement, and lack of housing and services for unfunded consumers all prevent or slow discharge to the community.

Discussion of Recommendation # 4

There are serious community-based discharge options that extend LOS. PCG studies are still relevant, and a place to begin identification of needed resources.

Recommendation # 5

Uniformly track and report discharge barriers occurring at state hospitals

Project Findings Supporting Recommendation # 5

- Discharge barriers negatively impact UM throughout the entire hospital continuum.

- These barriers are currently not being tracked by the RSNs in a systematic way. The state hospitals are tracking, but not systematically reporting them. Reporting such barriers to the MHD is essential to understanding the intra-system challenges to timely, appropriate discharge.

- Anecdotal data about discharge barriers is well known. Quantitative data is necessary to understand which consumers remain hospitalized because of lack of appropriate discharge options.

Discussion of Recommendation # 5

Uniformly track and report discharge barriers occurring at state hospitals

Recommendation # 6

Data collection strategies are fragmented and inconsistent throughout the system. At times, RSN and MHD data are discordant. We recommend conducting a root cause analysis of why there are discordant data reports between the MHD and some RSNs.

Project Findings Supporting Recommendation # 6

- UM data reporting methods are not consistent across the state hospitals.
- There are concerns between system entities regarding accuracy of data reports. While there has been some efforts made to investigate why discordant data exists, this issue has not been resolved.

Discussion of Recommendation # 6

What should be done about fragmented data strategies and often discordant data reports?

Three Additional Challenges for Discussion

1. Tensions between UM/UR and consumer choice. Challenges revealed by consumer key informant and RSN interviews.

2. How best to manage hospital utilization and discharge options for consumers who do not meet access to care criteria for outpatient care.

3. UM and ITA

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Mental Health Housing Action Pan

Prepared by Common Ground
with assistance from
AIDS Housing of Washington

June 2007

Key Elements

- Target population
- Housing model
- Goals 2007–2010 and 2010-2015
- Financing assumptions
- Capacity building
- Policy and resource coordination

Common Ground

Target Population

- Consumers served through PHP, PACT, PALS replacement
- Single adults, families, and seniors
- Approximately 5,000 units needed
- Highest priority = consumers cycling through hospitals, jails, streets, shelters

Common Ground

Housing Model

- Range of housing options including licensed and independent community housing
- Plan focus on permanent supportive housing
  - Largest gap
  - Top priority for consumers

Common Ground

Permanent Supportive Housing

- In apartments or single family homes
- Consumers have lease
- Supporting services on site or on call 24/7
- Caseloads 1:8 – 1:15
- Access to short-term crisis respite beds
- Incentives for landlords

Common Ground

Landlord Incentives

- Access to case management 24/7 for tenant crises
- Opportunity to master lease units
- Access to risk mitigation fund for excess costs of leasing to mental health consumers

Common Ground

Goal: 760 Units PSH 2007-2010

- 500 developed
- 260 leased from existing stock
- 66% single adults, 21% families, 13% seniors
- Up to 60% for PACT consumers
- Up to 70% for homeless MH consumers
- Up to 80% in RSNs with urban centers

Common Ground

Goal: 1,600 Units PSH 2010 -2015

- 1,050 developed
- 550 leased from existing stock
- Broader geographic spread
- More units for seniors
- More units for non-homeless consumers moving from more restrictive community settings

Common Ground

Draft Financing Assumptions 2007-2010

- $86.4M capital for 500 units
  - 60% $ already secured
  - Remaining can be secured within existing resources
  - Federal: McKinney, 811, HOME, CDBG
  - State: HTF, LIHTC, 2163
  - Local: 2060, 2163, 1359, local levies

Common Ground

Draft Financing Assumptions 2007-2010

- $5.3M for operating/rent subsidy
  - 35% already secured
  - Remaining $3.45M must compete with other populations for
    - Section 8
    - State and local O&M from 2060
    - State 2163
    - Local 2163 and 1359
    - Local levies and .1% sales tax

Common Ground

Draft Financing Assumptions 2007-2010

- $15.4M in supporting service costs for 760 units
  - Based on $7,500 per year per single adult and $9,000 per year per family
  - Funding secured for up to 550 units for PACT and PALS consumers
  - Funding for remaining units must come from existing or additional $ within RSN contracts
- $1M risk mitigation fund

Common Ground

Draft Financing Assumptions 2010-2015

- Capital - $302M for additional 1,050 units
- Operating/rent subsidy - $11M for 2,360 units
- Services - $367M for 2,360 units
- Requires significant increases and/or new sources for capital, operating, and services

Common Ground

Capacity Building

- RSN and MH provider capacity for PSH varies
- technical assistance investment from MHD for PSH
- Tap additional TA and pilot project funding from CTED
  - Priority for TA investment=local level tied to production of additional units

Common Ground

Coordination of Policy Resources at State and Local Levels

- Among housing and service providers
- Between RSNs and local funders
- Between MHD and RSNs
- Among state agencies

Common Ground

Selected Results from May 2007 Public Forum

- In addition to affordability, the top three barriers for landlord renting to individuals with mental illness.
  1. Criminal histories
  2. Poor credit
  3. Lack of 24-7 access to problem solving mental health staff

Common Ground

Forum Results cont'd

- RSNs should include "low barrier, housing first" programs with few requirements (e.g., being able to drink in your apartment, housing not contingent on treatment compliance).
  - 47% strongly agree
  - 18% strongly disagree

Common Ground

Forum Results cont'd

- The top three incentives that might encourage private landlords to rent to people with mental illness:
  1. Guaranteed stream of rent payments through master leasing
  2. Protection from liability for renting to people with past felony convictions
  3. Guaranteed 24/7 emergency response for tenant crises

Common Ground

Forum Results cont'd

- Top three policy/partnership strategies to achieve plan goals
  1. Closer coordination of policy and funding decisions among state agencies
  2. Greater collaboration with housing authorities and housing providers
  3. Short term crisis options while holding housing unit

Common Ground

Forum Results cont'd

- Where should permanent supportive housing rank among RSN priorities for unmet needs:
  - 3% Low priority
  - 12% Medium priority
  - 44% High priority
  - 41% Top priority

Common Ground

Next Steps

- Distribute/present final Housing Action Plan to key stakeholder groups
- Convene policy/resource discussions between MHD and CTED Housing Division
- Adjust RSN contracts to prioritize PSH

Common Ground

Next Steps cont'd

- Secure additional technical assistance and pilot project dollars from MHD and CTED
- Develop 2008 joint DSHS/CTED/DOC budget proposal for PSH

Common Ground

For more Information

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Common Ground

Washington State System Transformation Initiative

Mental Health Benefits Design Project Update and Discussion of Next Steps

TRIWEST GROUP

Andrew Keller, PhD

June 21, 2007

Major Topics for Today

- Review of May forum results
- Review of assumptions for cost analyses
- Discussion of next steps

Forum Feedback: Reasons For and Against Making a Change in ACS

- Reasons for this change (in rank order from May Forum):
  1. Broader lack of access for people with mental health needs, but less functional impairment
  2. Bureaucratic burden on RSNs & providers (Legal #1)
  3. Lack of access for high-risk populations in need of outreach
  4. Too little time managing people's care (Legislative #1)
- Also concerns about making a change (not in rank order, since they varied widely across stakeholder groups):
  - ✓ Concern unmet demand will create major additional costs (#1 for most)
  - ✓ Overlap between roles of RSNs vs FFS/Healthy Options (Other System #1)
  - ✓ Concern about diluting the ability of RSNs to meet high need cases if their mission is expanded to include lower need cases (RSN #1, Legislative #2)
  - ✓ Other individualized concerns (Consumer #1, Family #2, Other #1)

Feedback on Possible Changes in Current Implementation of the ACS

Which of the following statements best represents your view about potential changes in ACS implementation?

52% Change the requirements so that RSNs can serve all people with covered mental health diagnoses

32% Change the criteria so that RSNs still serve only those most in need, but they are also able to outreach high-need cases

12% No opinion – Not enough information provided to rate

4% Make no changes to the current Medicaid ACS

NOTE: Non-MH stakeholders (other system providers, other government, legislative staff, other) reversed the top two priorities

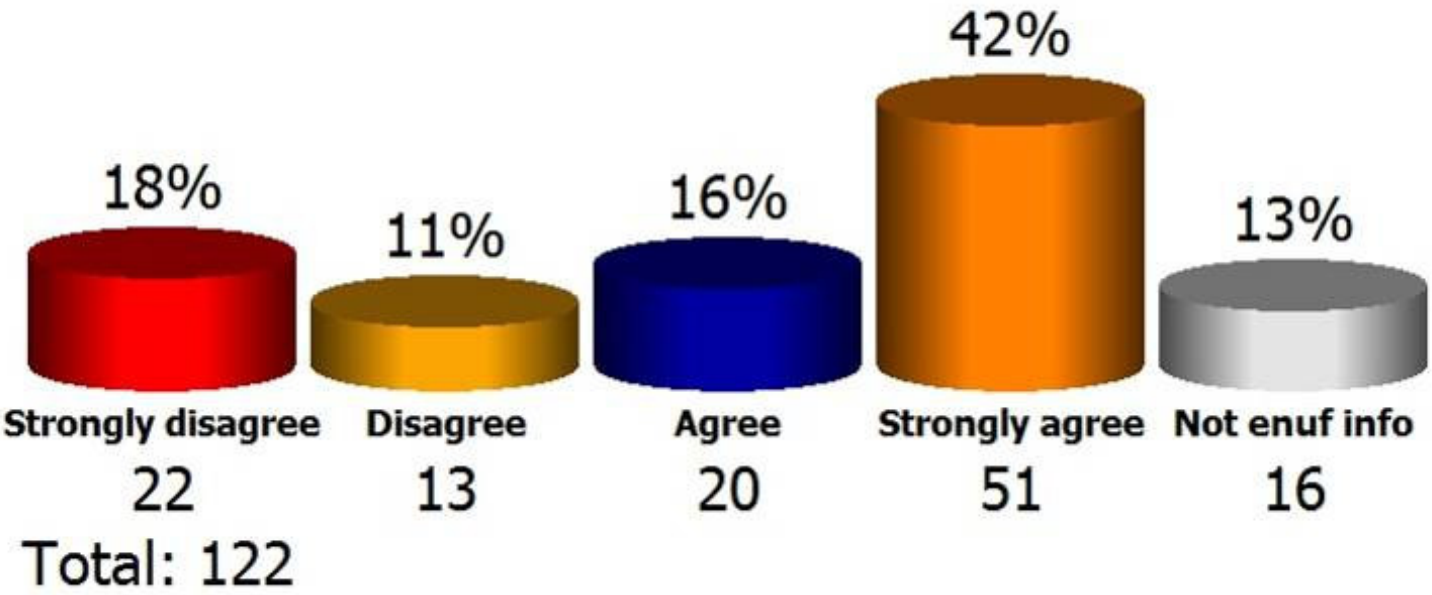
Feedback on How Best to Promote Best Practices

Which of the following statements best represents your view about how to promote Best Practices?

- 60% Prioritize three to five Best Practices for statewide implementation with new funds (adjusted rates, legislative appropriations) and "Centers of Excellence"
- 23% Do not promote Best Practices; focus on broader access (NOTE: consumers ranked this option highest)
- 12% Prioritize three to five Best Practices for statewide implementation with new funds (adjusted rates, legislative appropriations)
- 4% No opinion – Not enough information provided to rate
- 1% Make no changes: Continue to let RSNs choose Best Practices and develop them within current funding levels

Do you agree or disagree with the following statement:

Services directly provided by consumer and family-run organizations should be a top priority for statewide promotion by the MHD.



Vote on Proposed Endorsement of Consumer / Family-Run Services

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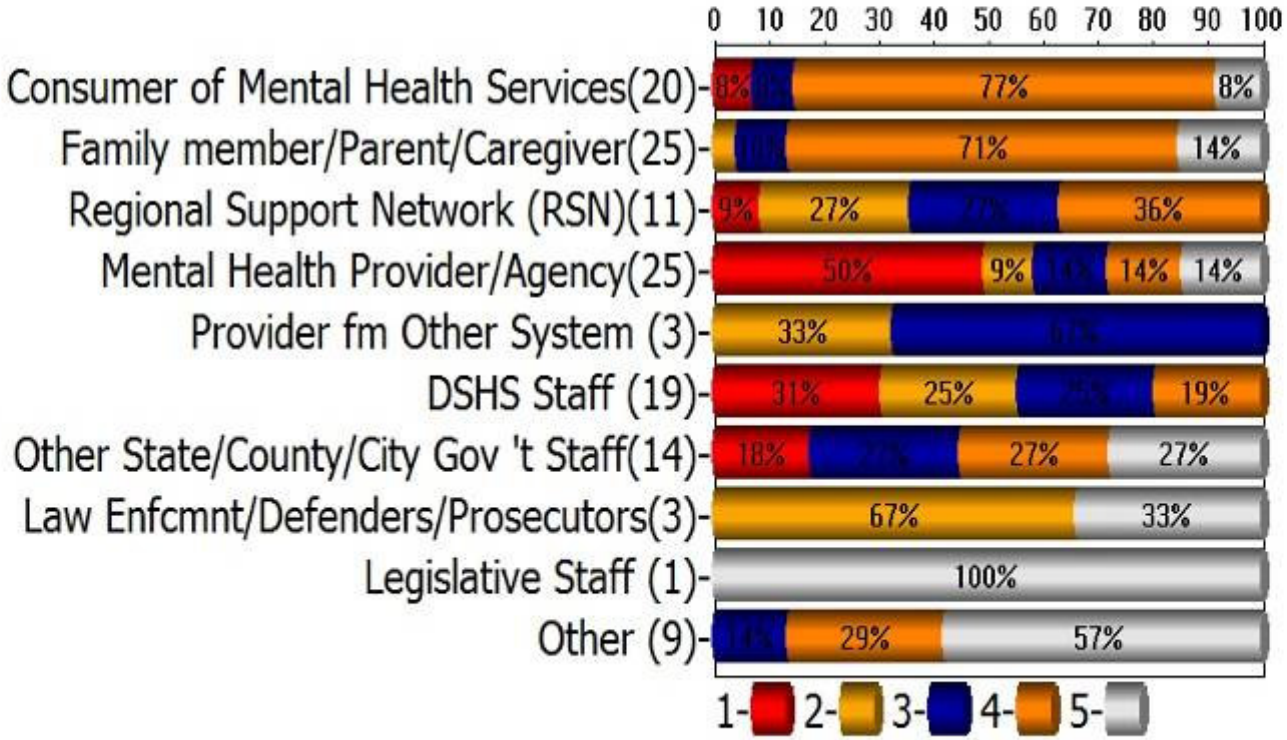
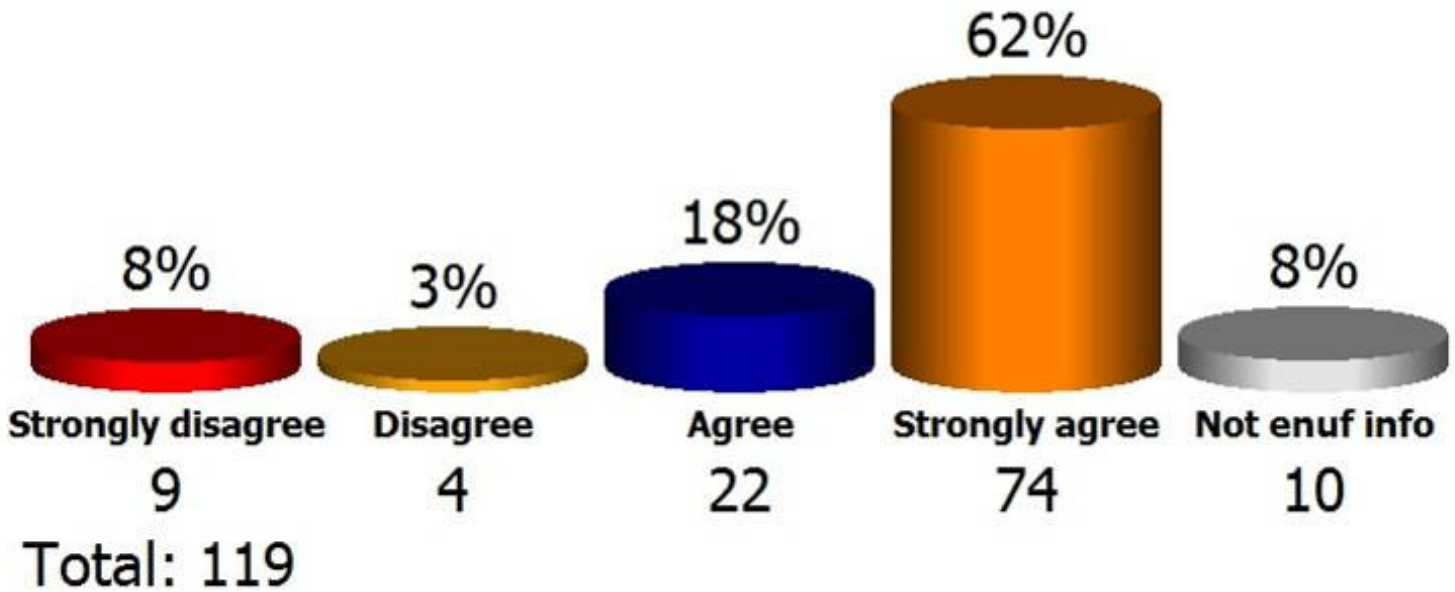


Do you agree or disagree with the following statement:

Integrated Dual Disorder Treatment
should be a top priority for statewide promotion by the MHD.



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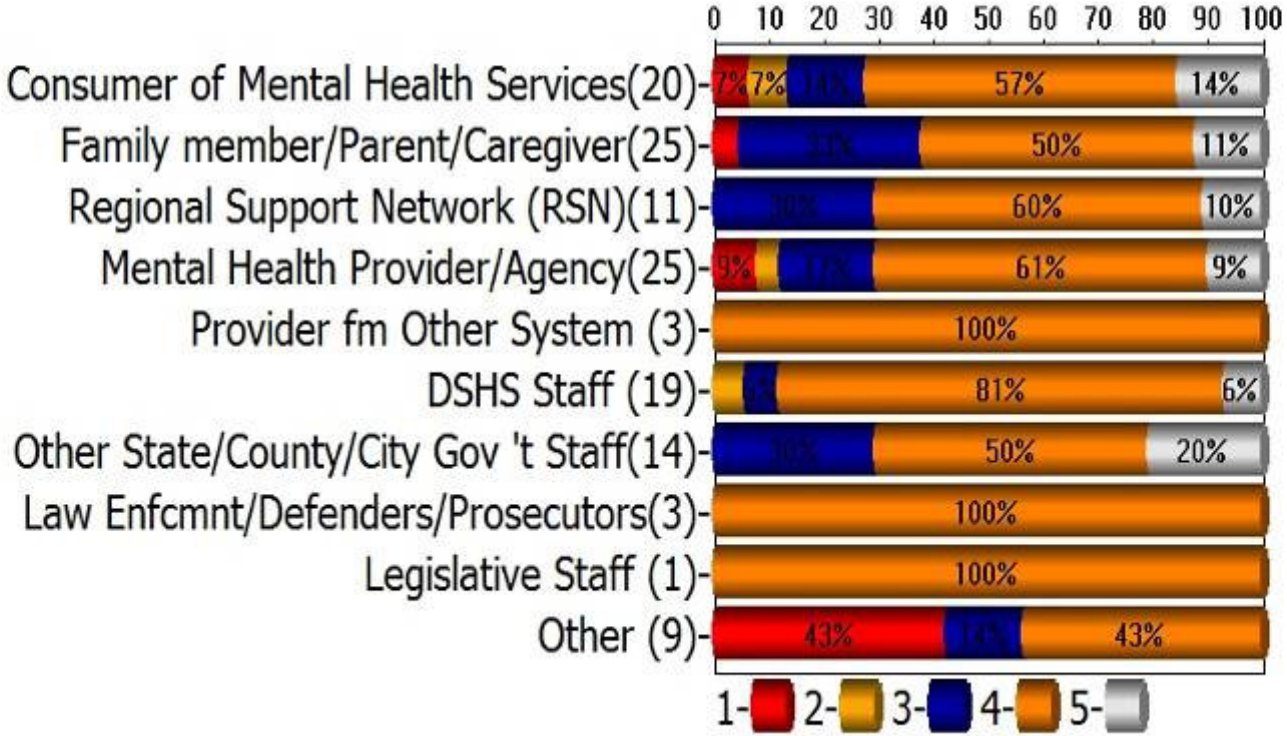

Do you agree or disagree with the following statement:

Collaborative Care in Primary Care Settings
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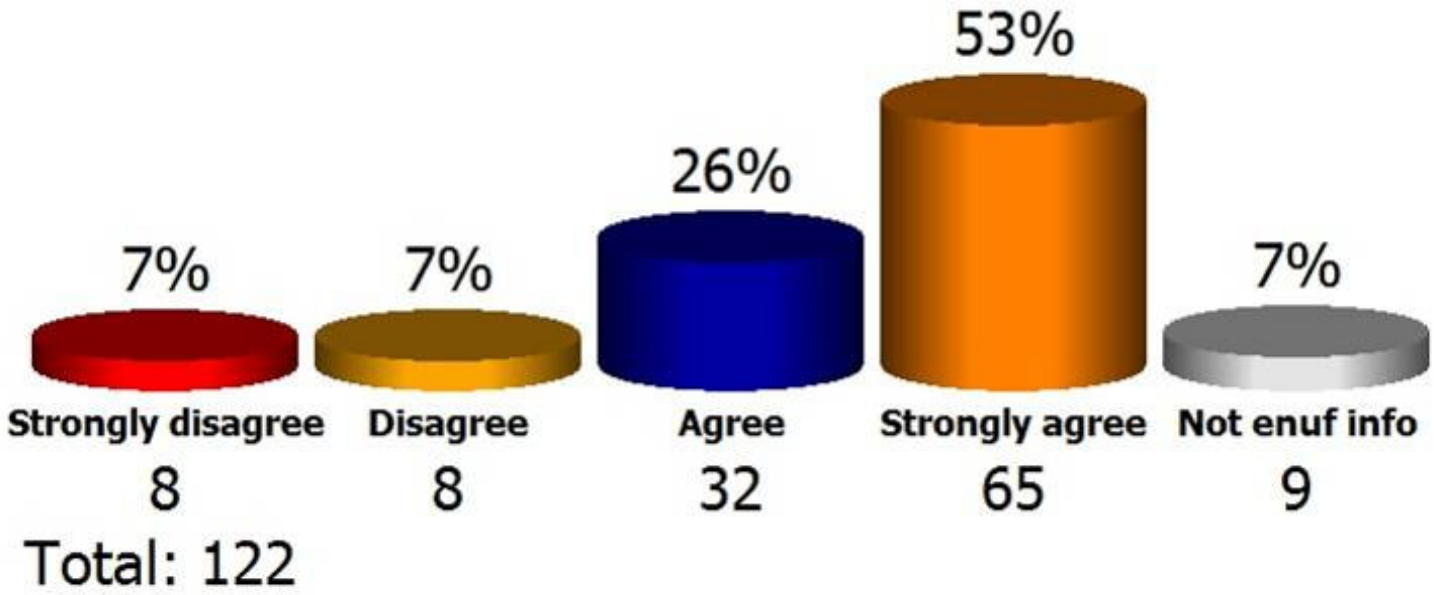

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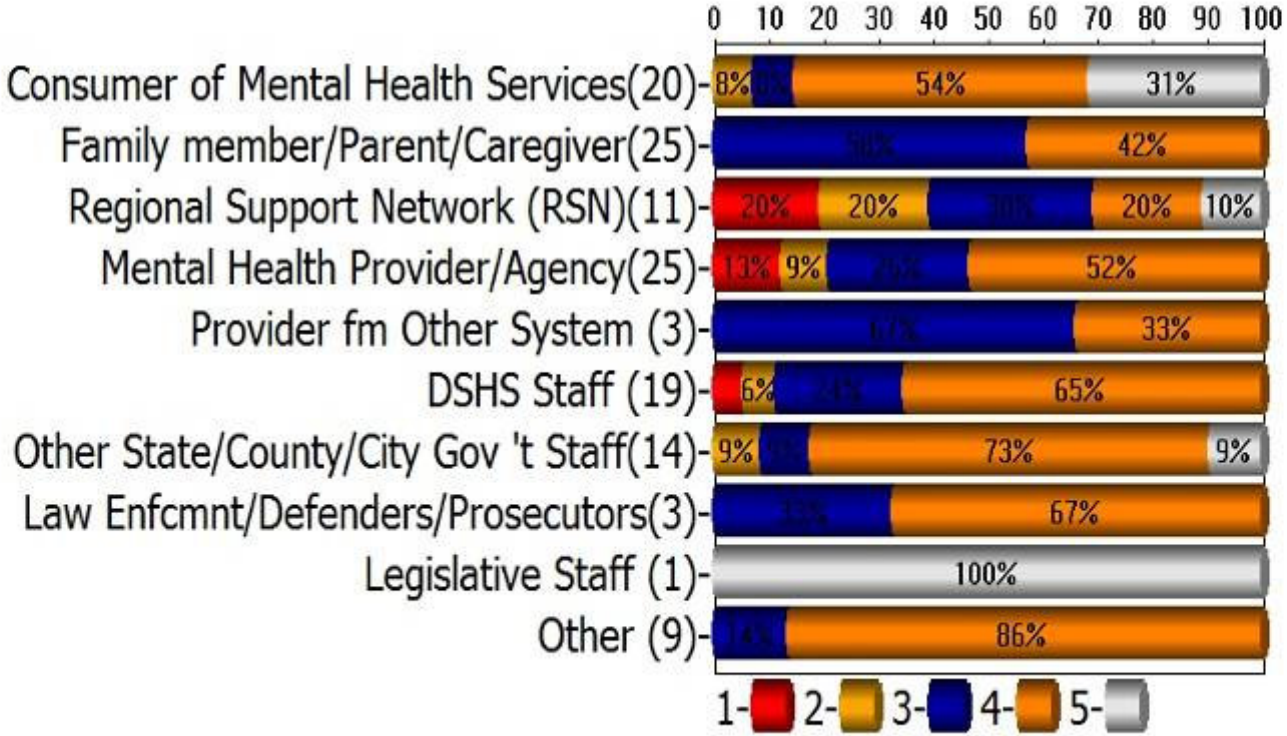

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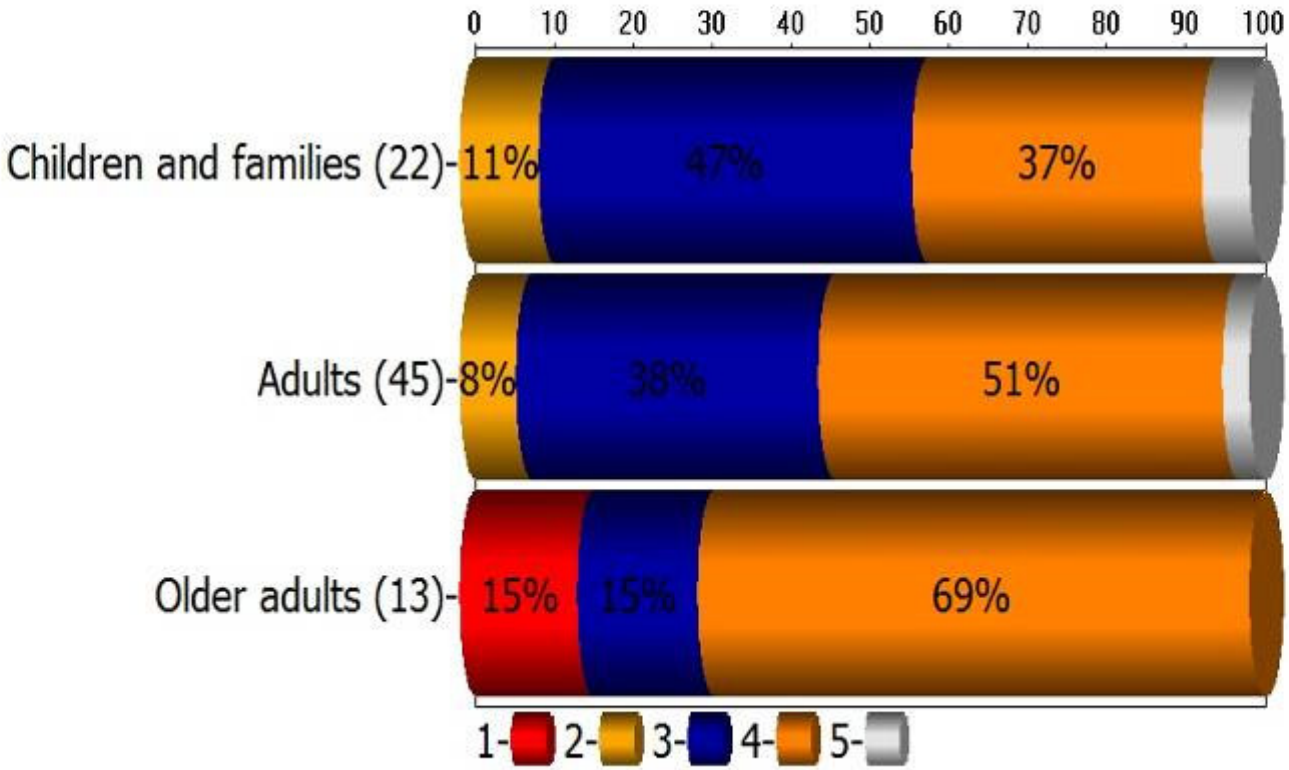

Do you agree or disagree with the following statement:

Multidimensional Treatment Foster Care
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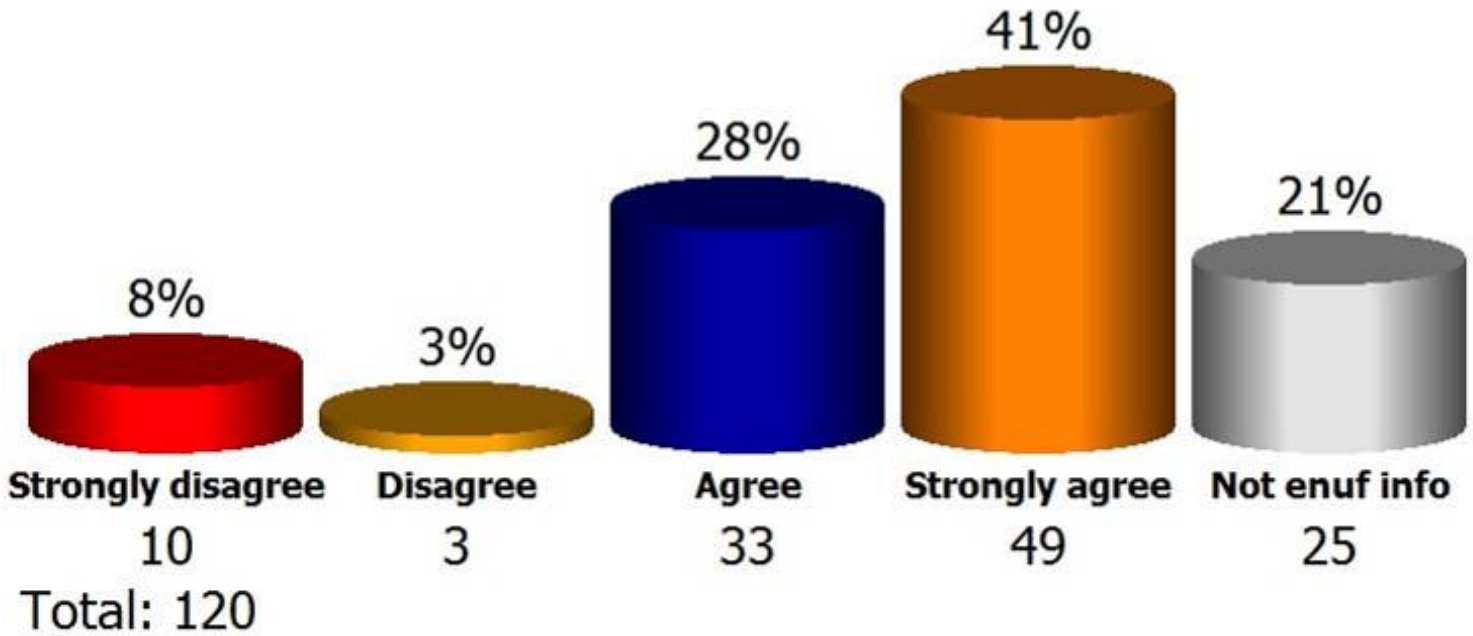

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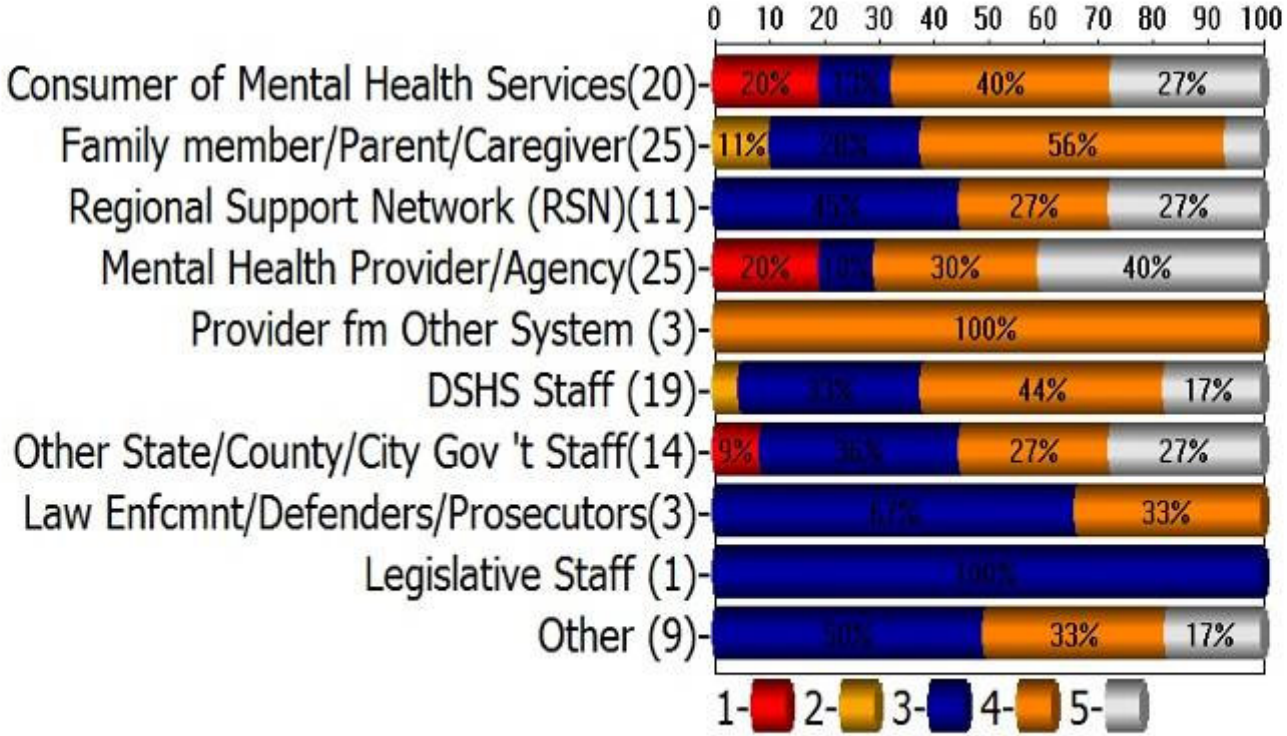

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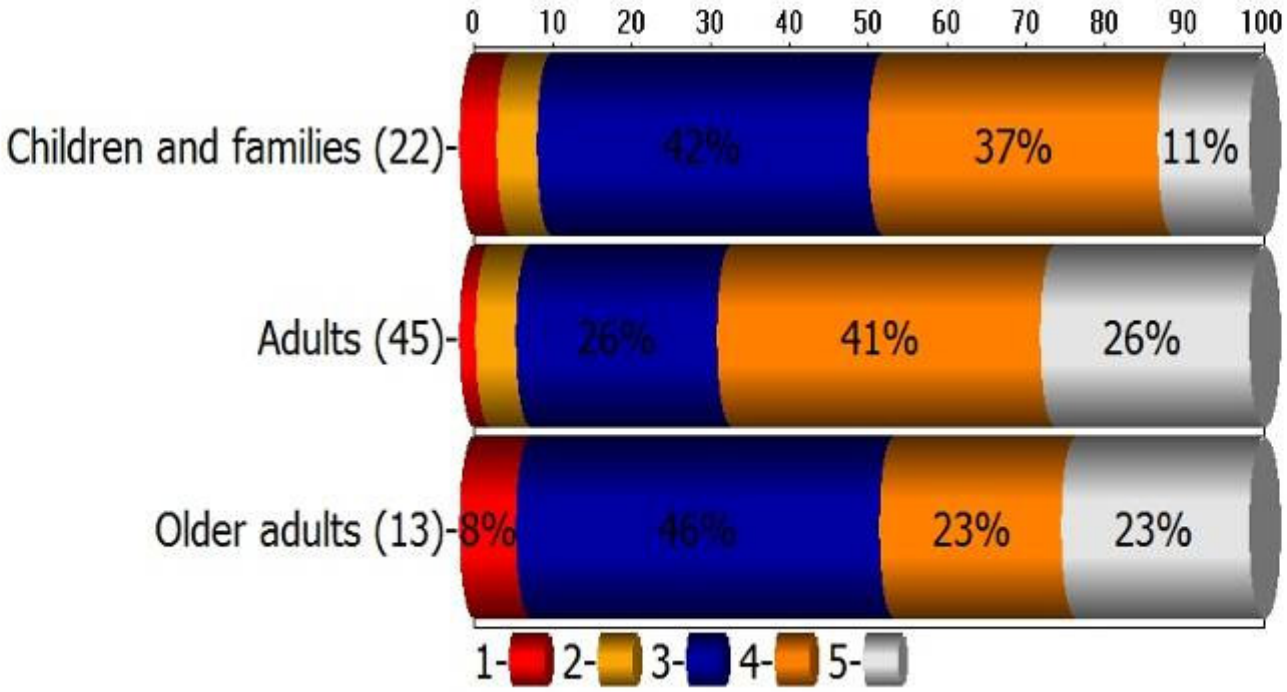
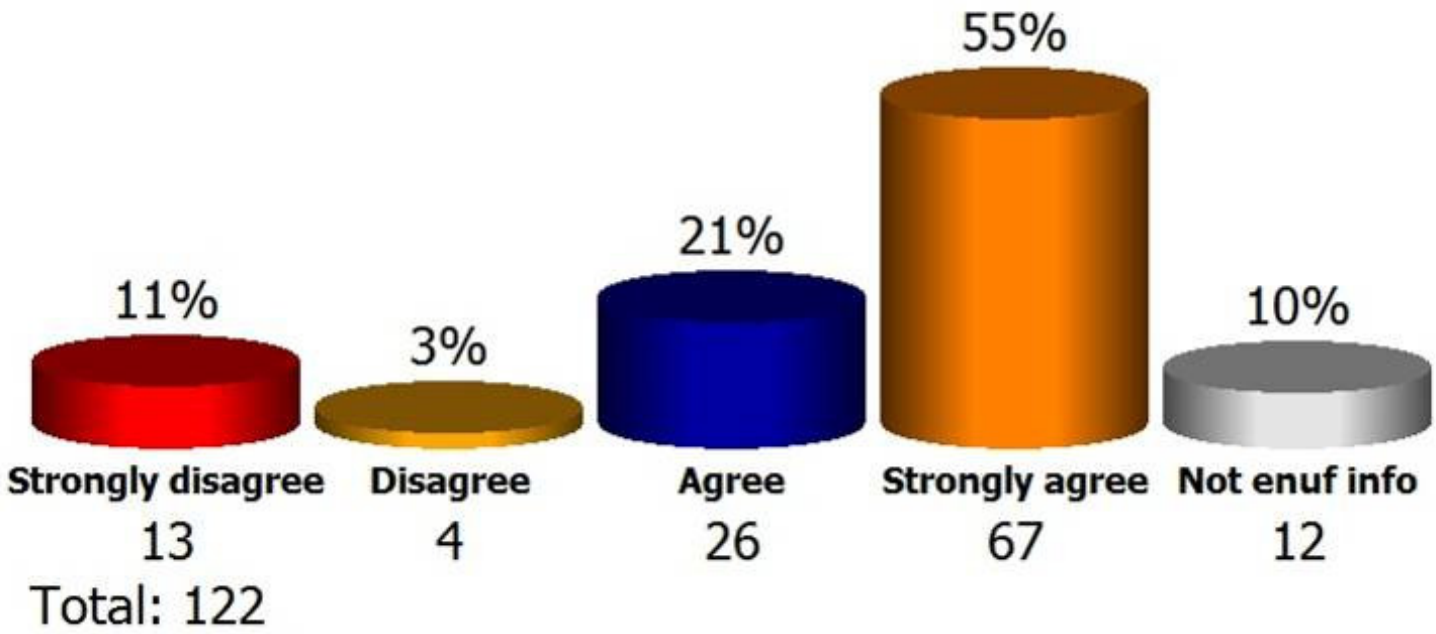


Do you agree or disagree with the following statement:

Wraparound Service Coordination
should be a top priority for statewide promotion by the MHD.



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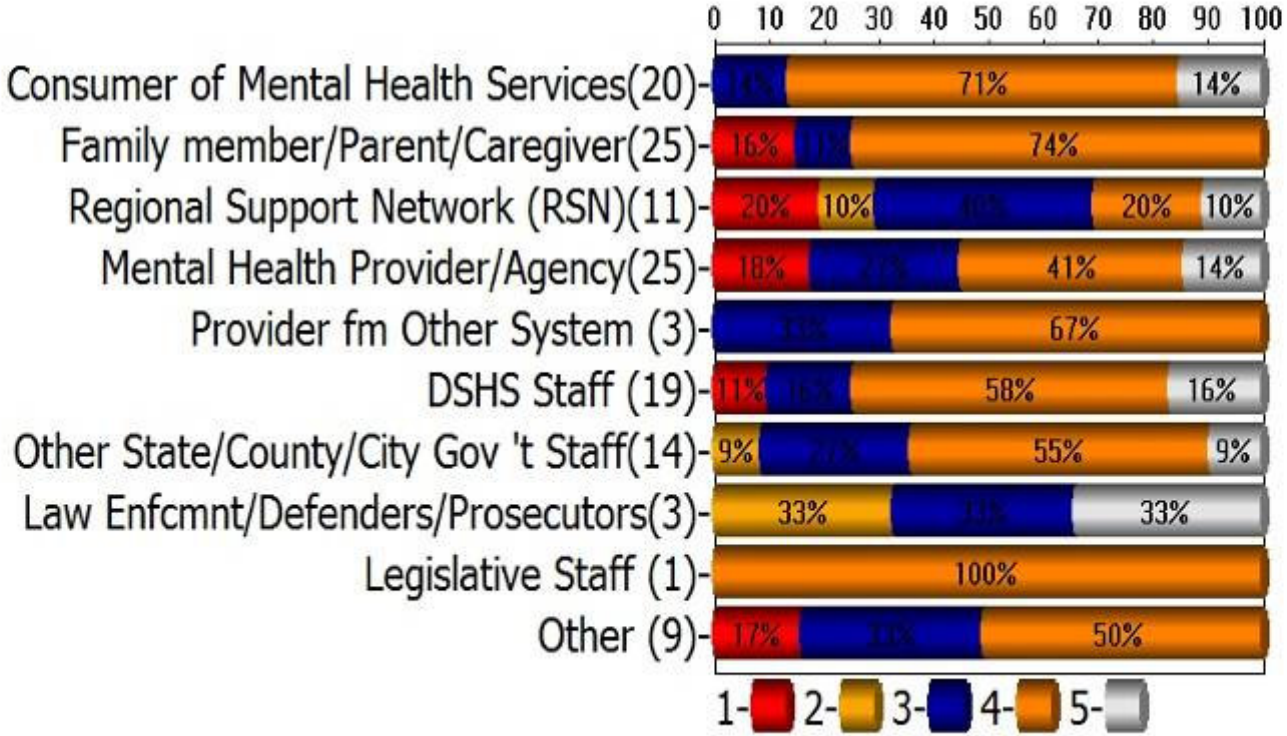

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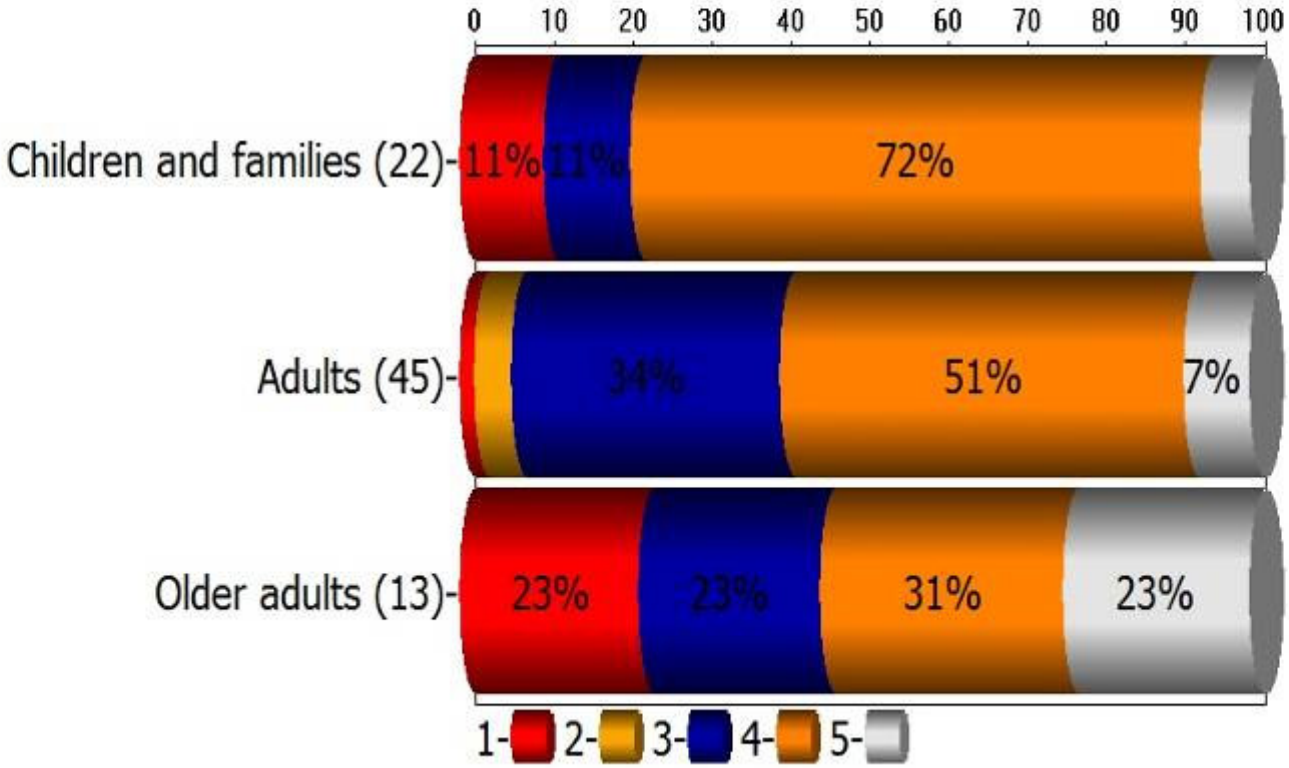


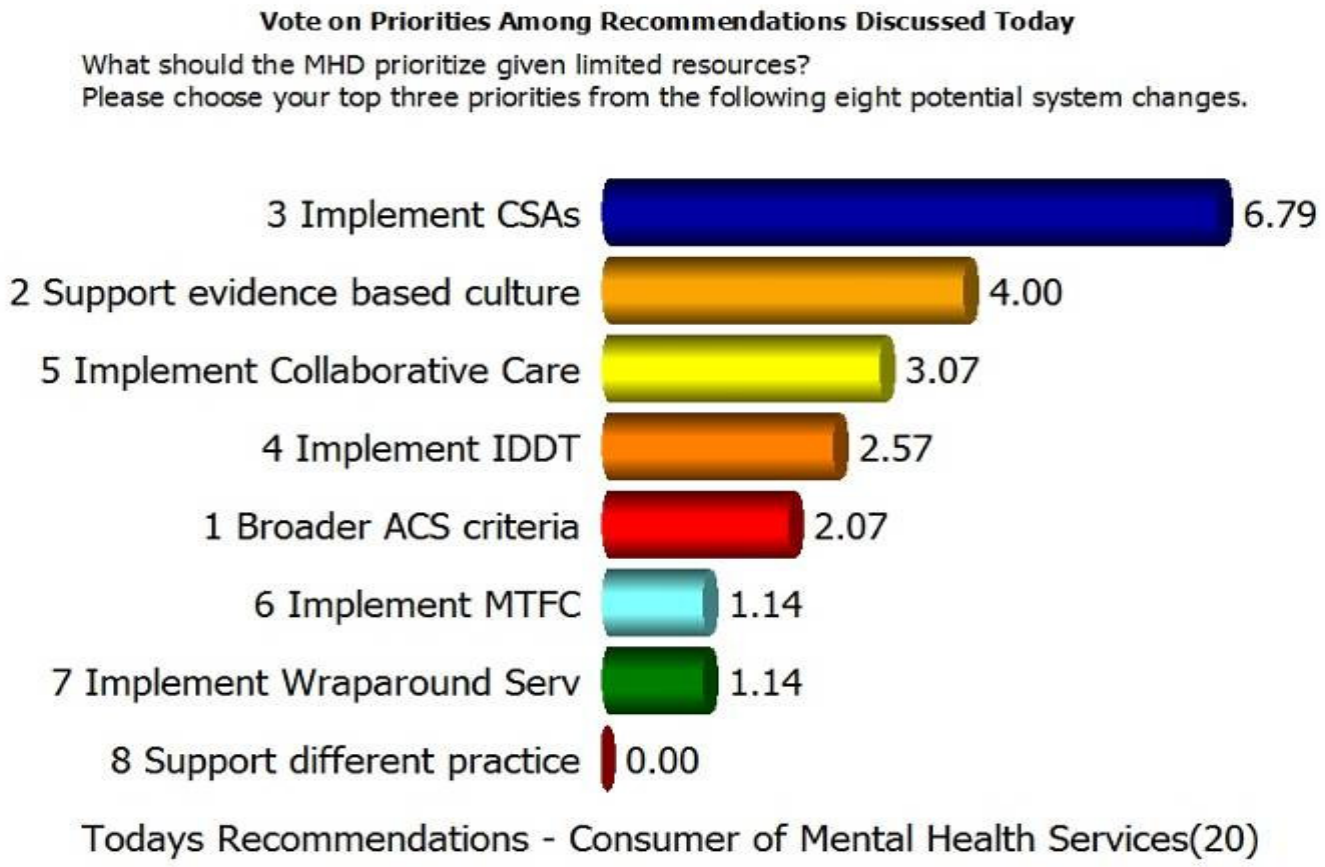
May Forum Prioritization Among Primary Recommendations

What should the MHD prioritize given limited resources? Please choose your top three priorities from the following eight potential system changes.

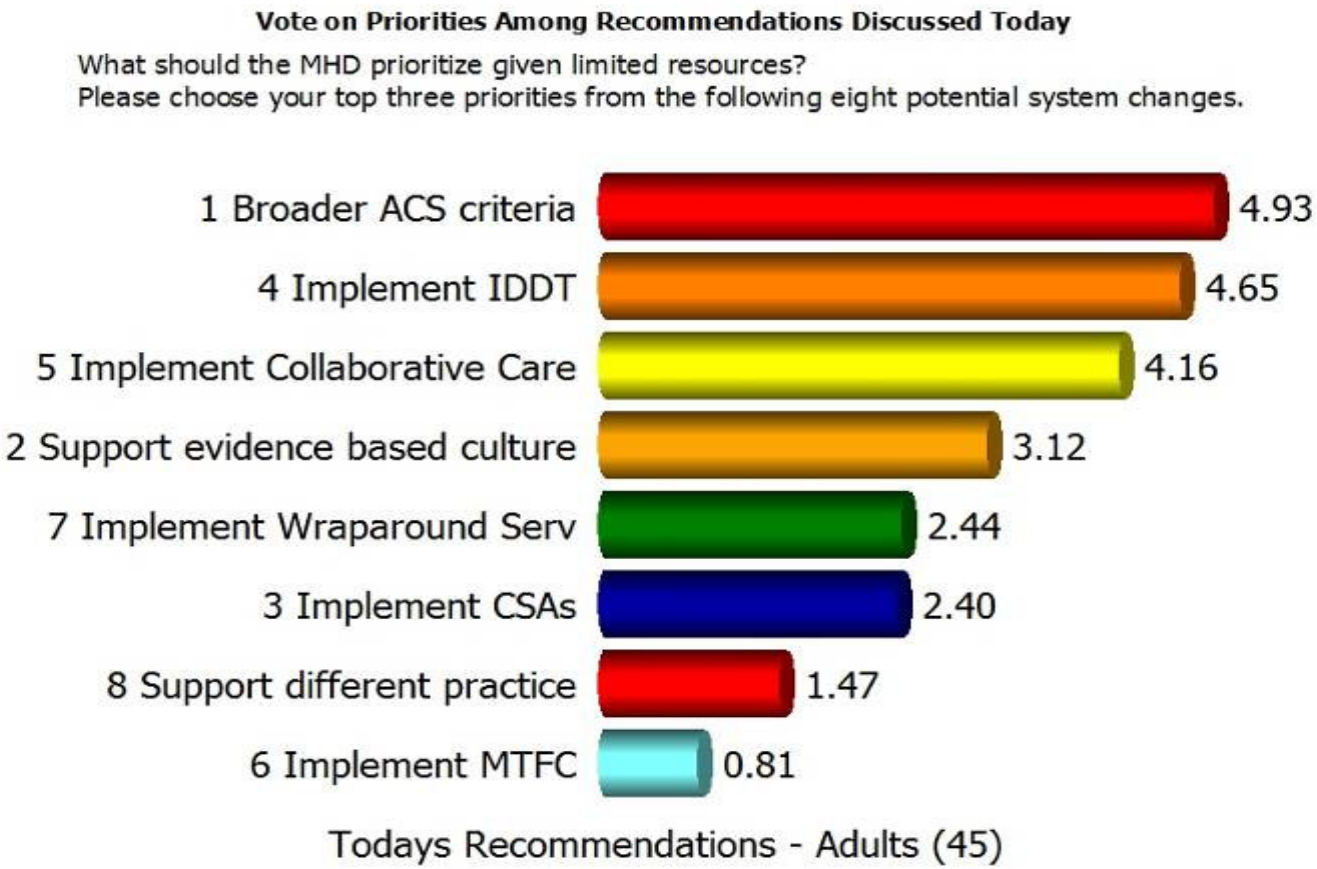
- Broader ACS criteria to allow RSNs to serve more people across the board
- Support for a broad-based "evidence-based culture"
- Statewide support to implement Consumer/Family Run Community Service Agencies (CSAs)
- Statewide support to implement Integrated Dual Disorder Treatment (IDDT)
- Statewide support to implement Collaborative Care in Primary Care Settings
- Statewide support to implement Multidimensional Treatment Foster Care (MTFC)
- Statewide support to implement Wraparound Service Coordination
- Statewide support to implement a different practice (Please specify which one on the voting card provided)

May Forum Prioritization Across All Stakeholder Groups

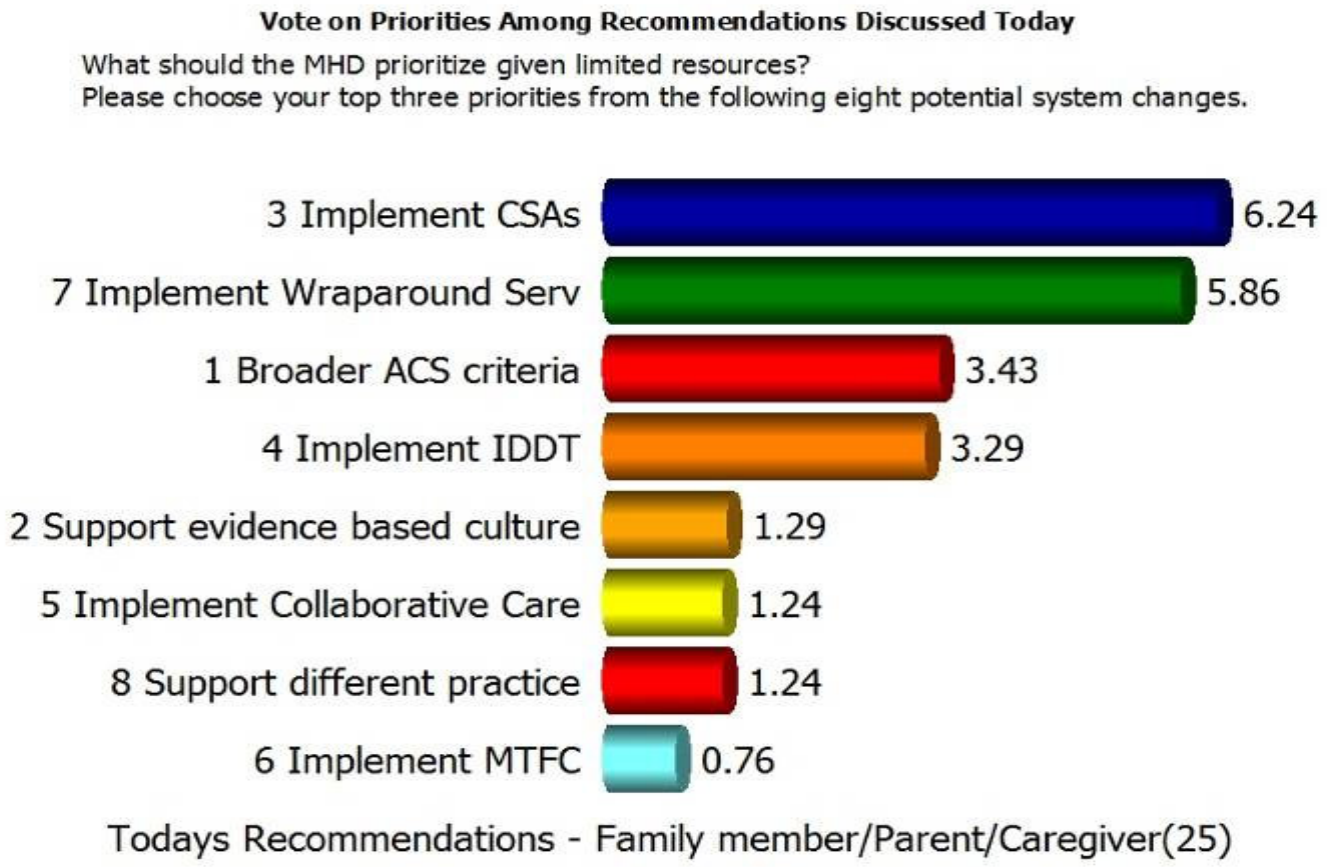
Consumer Prioritization Among Primary Recommendations



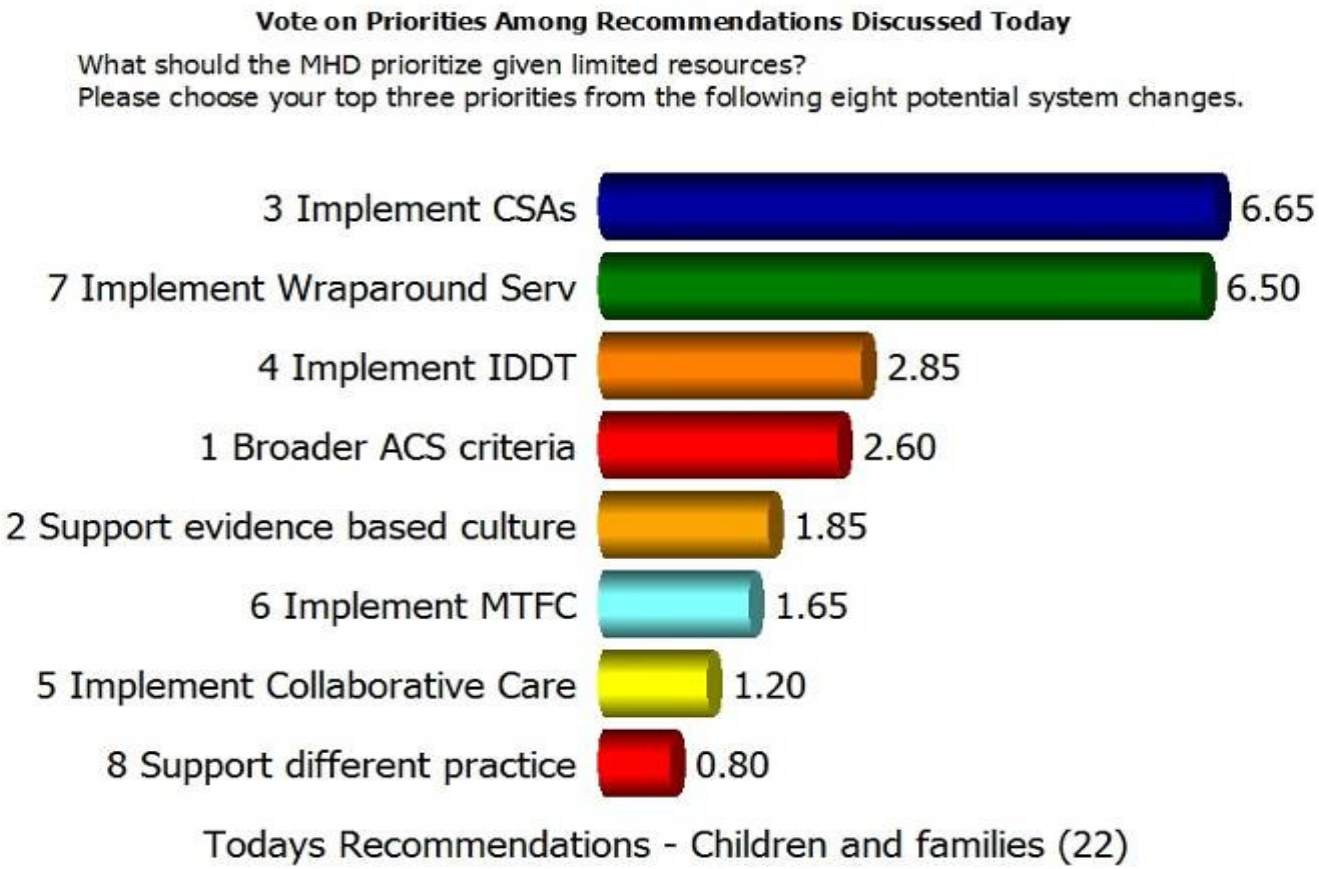
Adult Focus: Prioritization Among Primary Recommendations



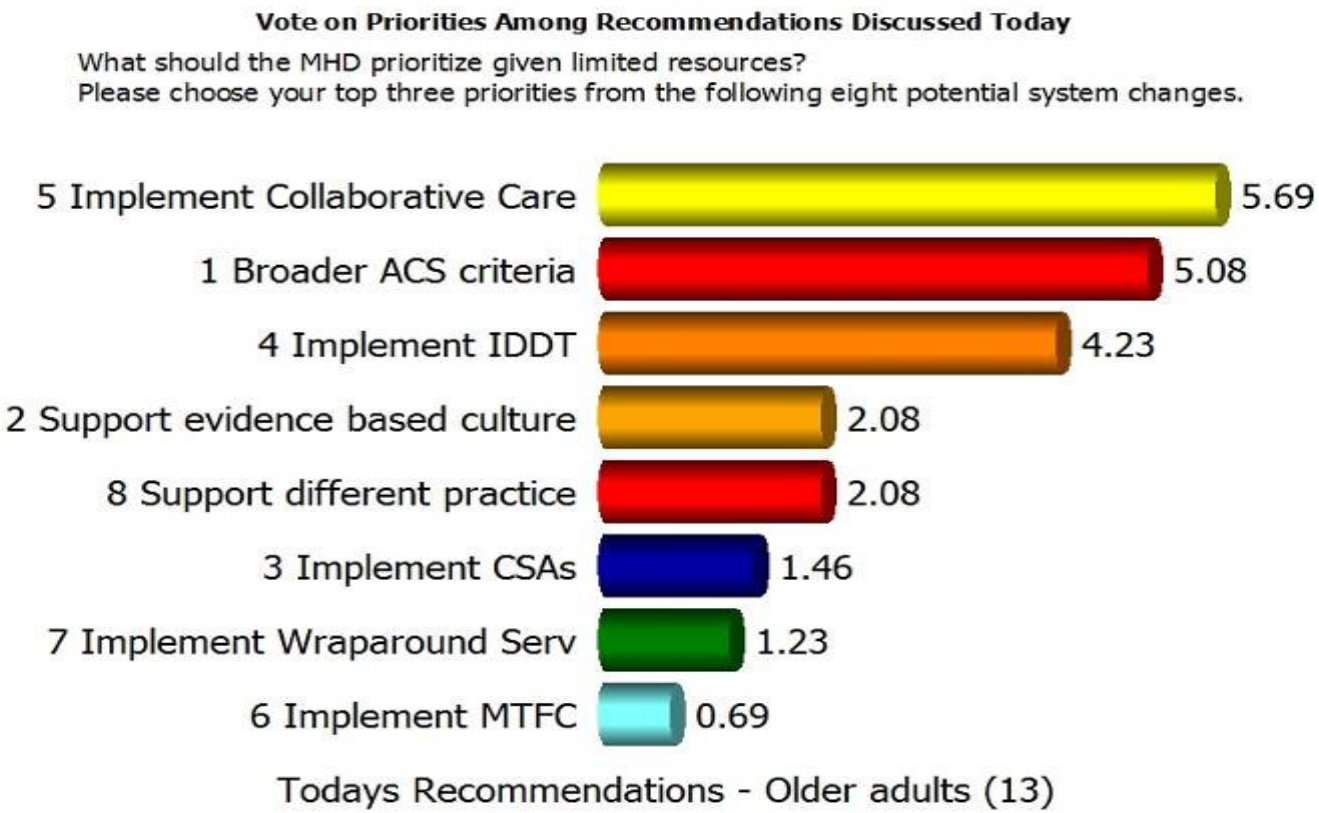
Family / Parent / Caregiver Prioritization Among Primary Recommendations



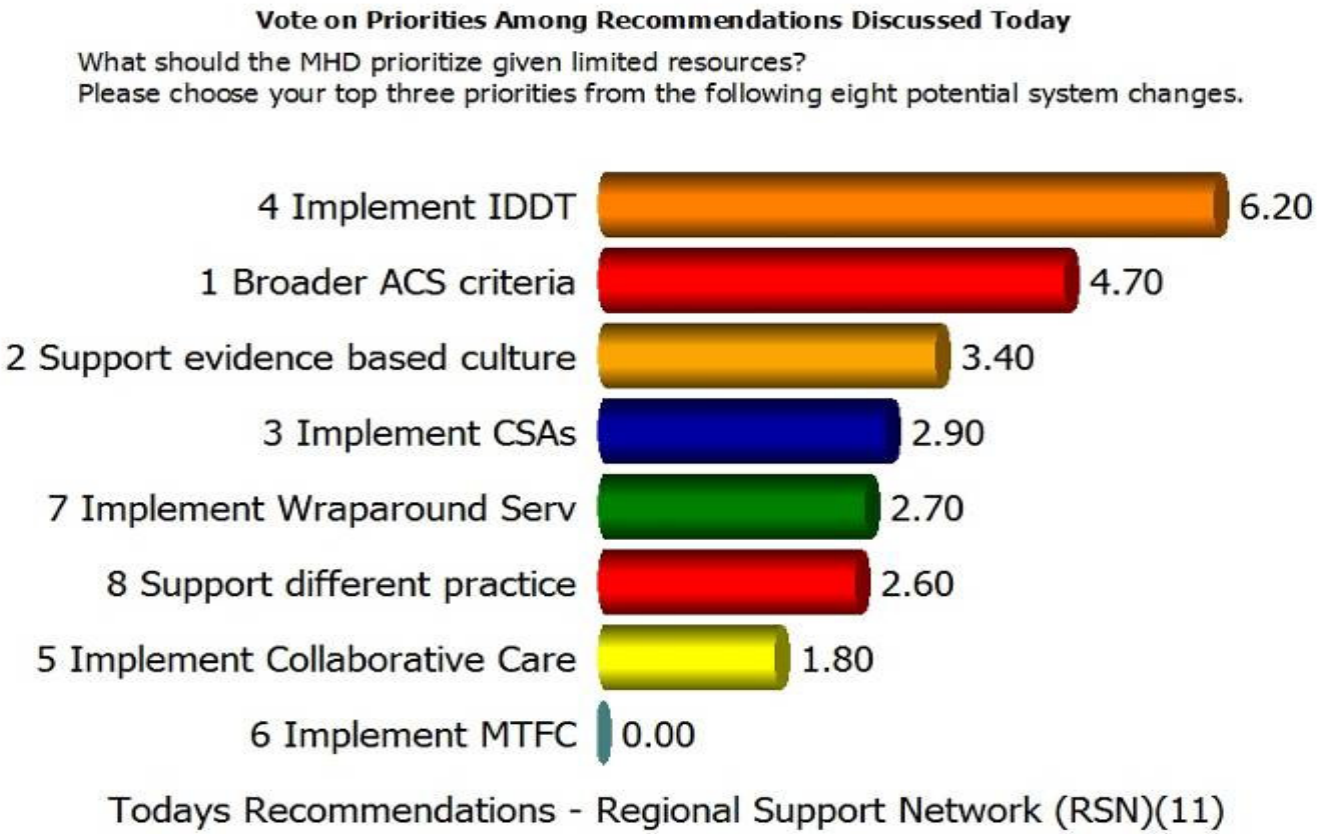
Child/Family Focus: Prioritization Among Primary Recommendations



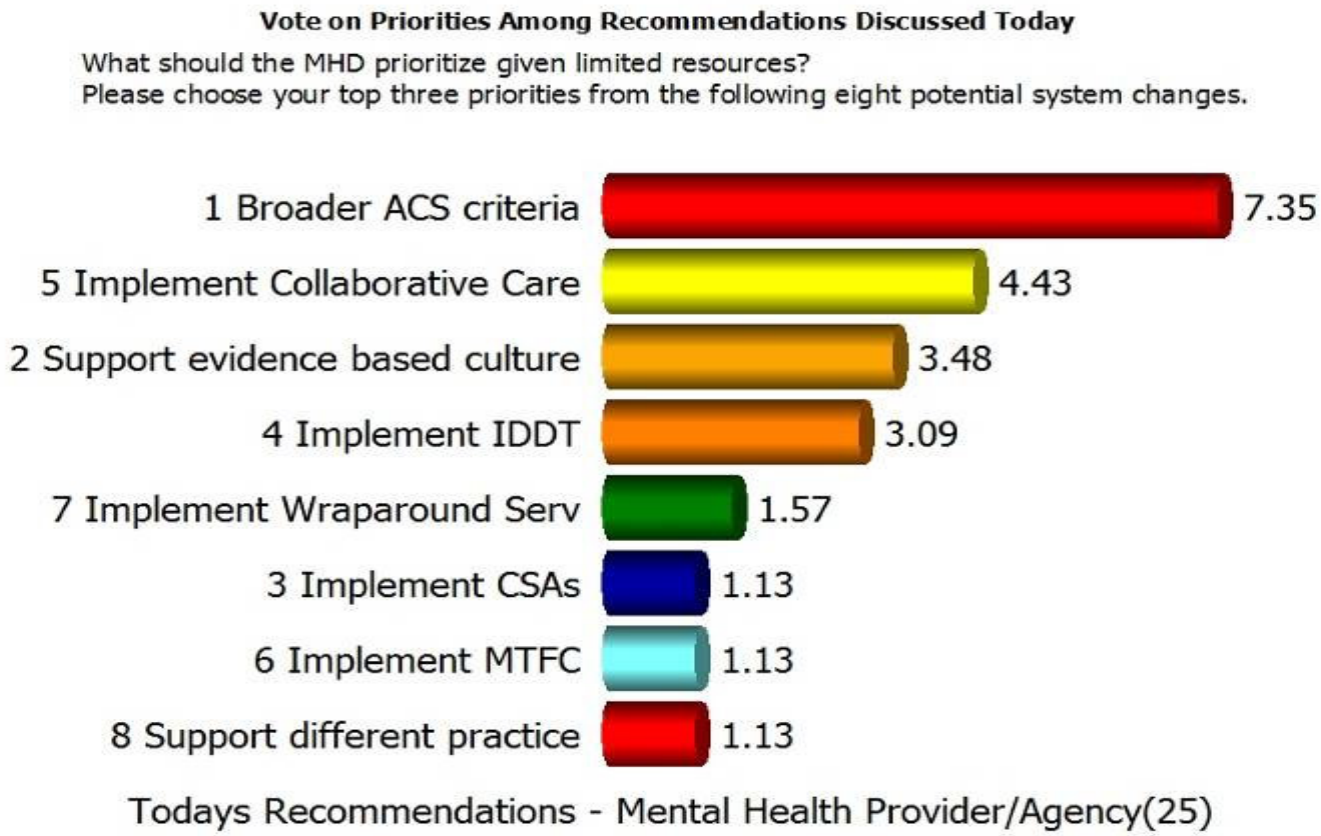
Older Adult Focus: Prioritization Among Primary Recommendations



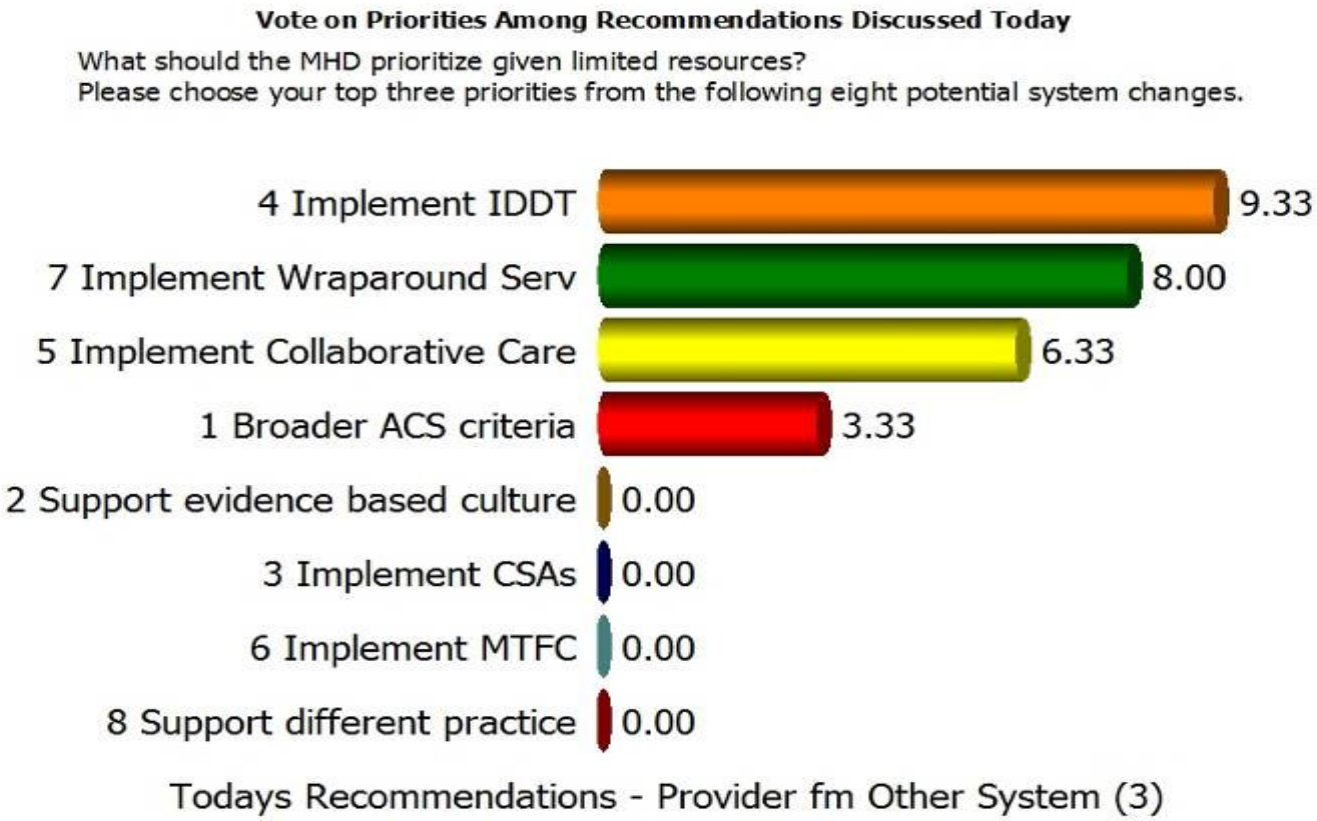
RSN Prioritization Among Primary Recommendations



MH Provider Prioritization Among Primary Recommendations

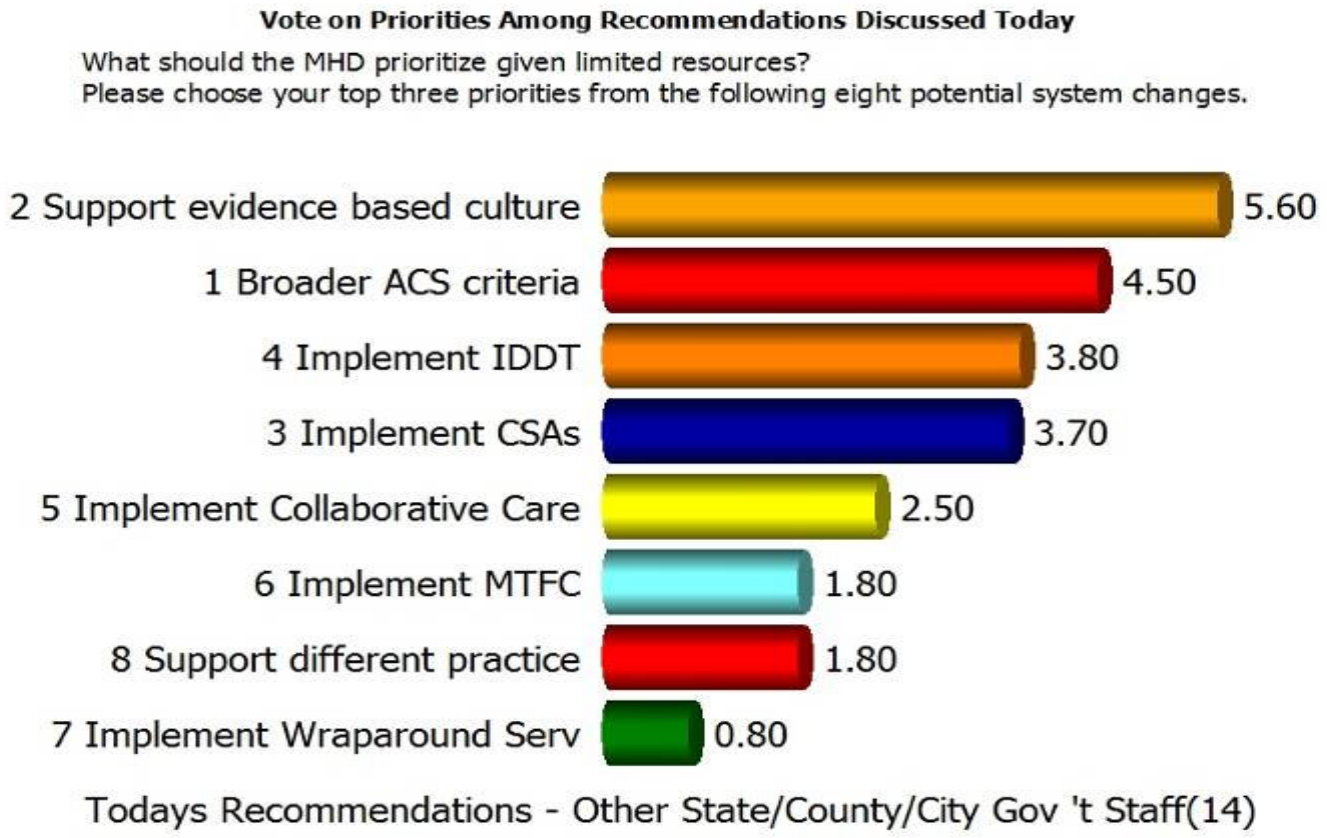


Other Provider Prioritization Among Primary Recommendations

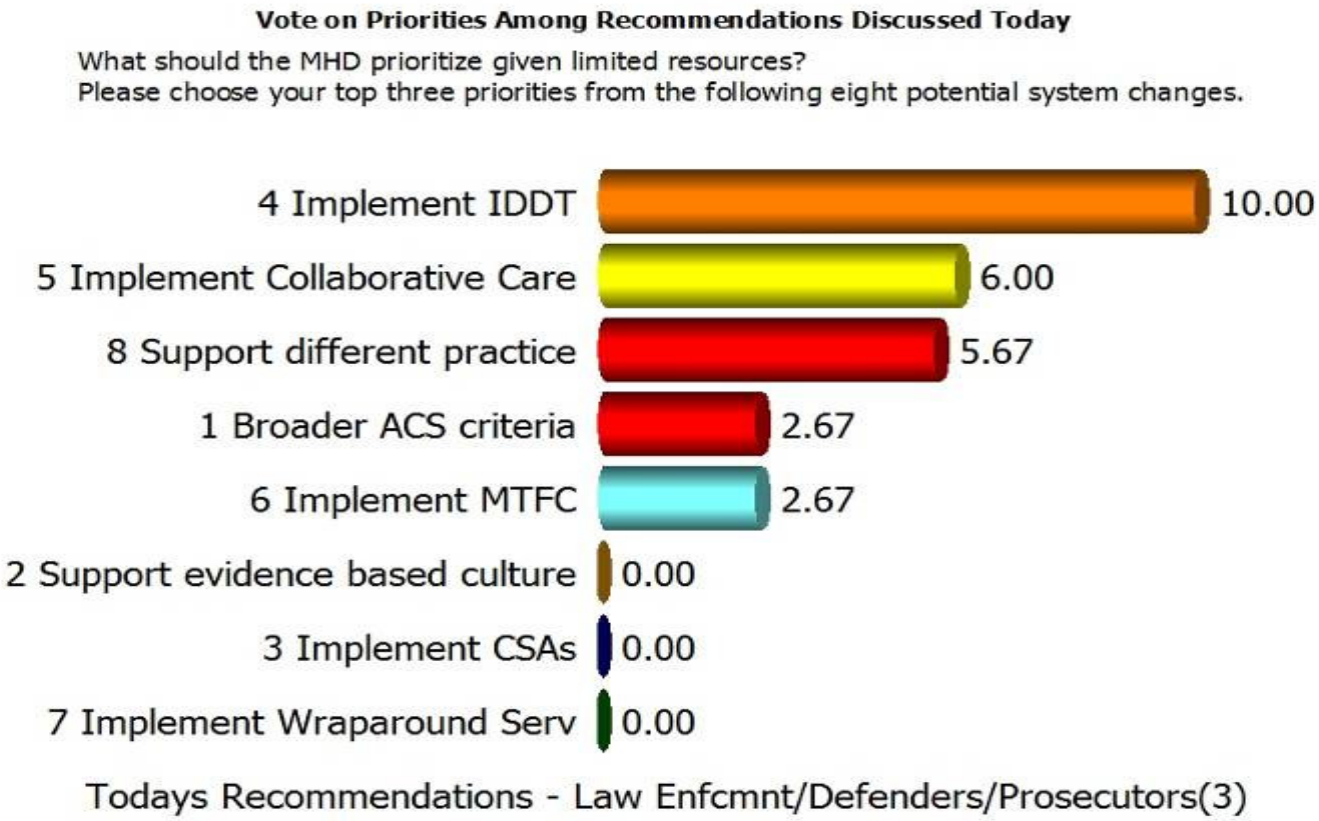


DSHS Prioritization Among Primary Recommendations

Other Government Agency Prioritization Among Primary Recommendations



Legal System Prioritization Among Primary Recommendations



Assumptions for Cost Analyses

- Cost estimates depends on the following parameters:
  - ✓ Estimate of Unit Costs – based on RSN estimates, current costs, national estimates
  - ✓ Estimate of COE Costs – based on costs of similar COEs
  - ✓ Estimate of Potential Utilization – based on RSN estimates, national estimates
  - ✓ Ramp-up Factor
  - ✓ Cost Offsets – can raise or lower overall costs
- Reviewed cost models with actuaries to determine reasonableness
- Goal: Give MHD reasonable initial estimates that can be refined with additional data

Assumptions for IDDT

- Estimate of Unit Costs – North Sound and Clark had both costed this out and there was minimal difference; Timberlands 1/7 the cost for more across the board model and King 1/3 more for criminal justice pilot
- Estimate of COE Costs – Adds minimal costs per member served
- Estimate of Potential Utilization – Triangulating from RSN estimates leads to approximately one percent of enrolled adults (5% of adults served) needing intensive services (2,971); GAIN projections from Jan-Mar 2007 showed about double this number ID's as Quadrant IV
- Ramp-up Factor – Assumed three years
- Cost Offsets – Conservative on this; up to 15% reduction in inpatient and residential after three years (5% a year)

Assumptions for Wraparound

- Estimate of Unit Costs – Focused on NWI model with 1:8 ratio
  - ✓ King (prorated to 1:8 from 1:15) and Wraparound Milwaukee only one-third of costs in Clark and Greater Columbia; looking into differences more closely
  - ✓ Plan to build up cost from Wraparound Milwaukee staffing model
- Estimate of COE Costs – Adds minimal costs a month per member served
- Estimate of Potential Utilization – Average of RSN estimates leads to approximately 0.56 percent of enrolled children (9.1% of children served) needing Wraparound (3,143 a year)
- Estimate of ALOS – National estimates 16 months; current WA much faster, other than in Greater Columbia
- Ramp-up Factor – Assumed three years; will take 45-70 teams
- Cost Offsets – Conservative on this; up to 15% reduction in inpatient and residential after three years (5% a year); low fidelity increases OP

Assumptions for MTFC

- Estimate of Potential Need – Harder to estimate, because new LOC
  - ✓ 2004 PCG study noted no LOC between inpatient and outpatient within MH system
  - ✓ What do we benchmark against? 91 CLIP beds; 93 community inpatient beds (down from 110 in 2004); CHAP beds
  - ✓ One estimate – 220 beds statewide, with 90% occupancy and 7.5 month ALOS (minimum 5 per RSN, maximum 40 for King); 0.9% of children served
  - ✓ Would this supplement or partially replace CHAP? Other modalities?
- Estimate of Unit Costs – Based on Kitsap, CA, JRA pilots, model
- Estimate of COE Costs
  - ✓ Higher costs per placement in first year, drops off after that
  - ✓ Not clear what role of COE would be here – partnership or independent
- Ramp-up Factor – 12 half teams (5 beds); 16 full teams (10 beds); 5 years?

Assumptions for Consumer/Family-Run and Collaborative Care

- Consumer / Family Run Services
  - ✓ Do not expect significant change in utilization of peer support units
  - ✓ Do not expect significant change in cost of peer support units
  - ✓ Do expect more clarity in types of peer support units
  - ✓ Other primary focus is re-tooling the certification process for peer specialists to separate child/family and adult tracks
  - ✓ Expect changes at service delivery level to be very incremental (2-3 sites)
- Collaborative Care
  - ✓ Disabled children and adults currently have very limited primary care under Medicaid FFS system
  - ✓ Primary impacts: (1) increased access (utilization); (2) higher per unit cost
  - ✓ Collaborative care model does not involve new service types; may require additional guidance, though (e.g., acceptability to bill joint sessions)
  - ✓ Primary focus is enhanced training / TA to promote CC models (plural)

Next Steps

- Brainstorm together about next steps
  - ✓ Supporting MHD decision-making process about priorities
  - ✓ Refining cost estimates and implementation planning for priorities
  - ✓ Additional coordination with allied systems, stakeholders
  - ✓ Other next steps

Contacting TriWest with Additional Input

If you have additional input or concerns you would like to share, please contact **Andy Keller** using the contact information below:

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Washington State System Transformation Initiative: *Review of Involuntary Treatment Laws*

June 21, 2007

Andrew Keller, Ph.D., TriWest Group
Jenifer Urff, J.D., Advocates for Human Potential

Goals for Today

- Review major findings
- Review May Community Forum results
- Discuss next steps

Community Forum: Background on Participants

129 participants responding to most Audience Response System (ARS) questions:

- 16 percent represented consumers
  - BUT **2/3** answered yes to the question: Have you ever been a consumer of mental health services?
- 17 percent represented family member/parent/ caregivers
  - BUT **half** answered yes to the question: Are you a family member or caregiver of a consumer of mental health services?
- 9 percent represented RSNS
- 20 percent represented providers

Major Finding #1

Stakeholders in WA State expect involuntary treatment laws to meet many different, and sometimes competing, policy objectives.

Community Forum: Involuntary Treatment Policy Objectives

Community Forum participants ranked potential policy objectives for their importance (scale 1-5):

- Ensuring that individuals receive mental health treatment that they need (4.6)
- Ensuring that parents can access needed mental health services for children and adolescents (4.2)
- Ensuring public safety (4.2)
- Diverting individuals from the criminal justice system and homelessness (3.9)
- Protecting individual civil liberties (3.9)

Major Finding #2

Despite a range of views about the use of detention and civil commitment, most people believe that, in at least some cases, alternatives to involuntary treatment exist.

Community Forum: Alternatives to Involuntary Treatment

74% of Community Forum participants agreed or strongly agreed with the following:

The use of civil commitment in Washington State too often reflects a lack of sufficient appropriate, recovery-oriented community services, and developing these services would lead to an overall decline in the need for civil commitment.

Community Forum: Factors Affecting Civil Commitment Use

Community Forum participants ranked the three factors they believe most affect the use of civil commitment in WA State:

- Insufficient access to mental health services (eligibility and availability)
- Lack of residential crisis alternatives
- Insufficient access to services, like PACT, for people with the most severe illnesses who have not benefited from traditional services
- Insufficient access to mental health services that consumers *want*
- Lack of housing and other community residential options
- Lack of specialized community services for special populations
- Subjective interpretations of the law by DMHPs
- Reaction by DMHPs and courts to high-profile incidents
- Actual language used in the ITA statute
- Lack of employment options

Major Finding #3

Washington State's definition of "mental disorder" is broader than many states in that it does not exclude specific diagnoses such as developmental disabilities, traumatic brain injury, or dementia.

Analysis Regarding Definition of "Mental Disorder"

Strengths:

- Breadth of definition provides flexibility
- People who meet civil commitment criteria receive services regardless of diagnosis or disorder

Challenges:

- People committed to inpatient psychiatric facilities may not be best served in that setting and may have longer lengths of stay
- Inpatient services become providers of last resort when needed services and supports for special populations are not available in the community

Analysis Regarding Definition of "Mental Disorder"

Options for reform:

- Narrowing the definition to include only certain mental illnesses
- Excluding specific diagnoses or conditions
- Creating separate commitment process to other licensed facilities for people with specific diagnoses or conditions

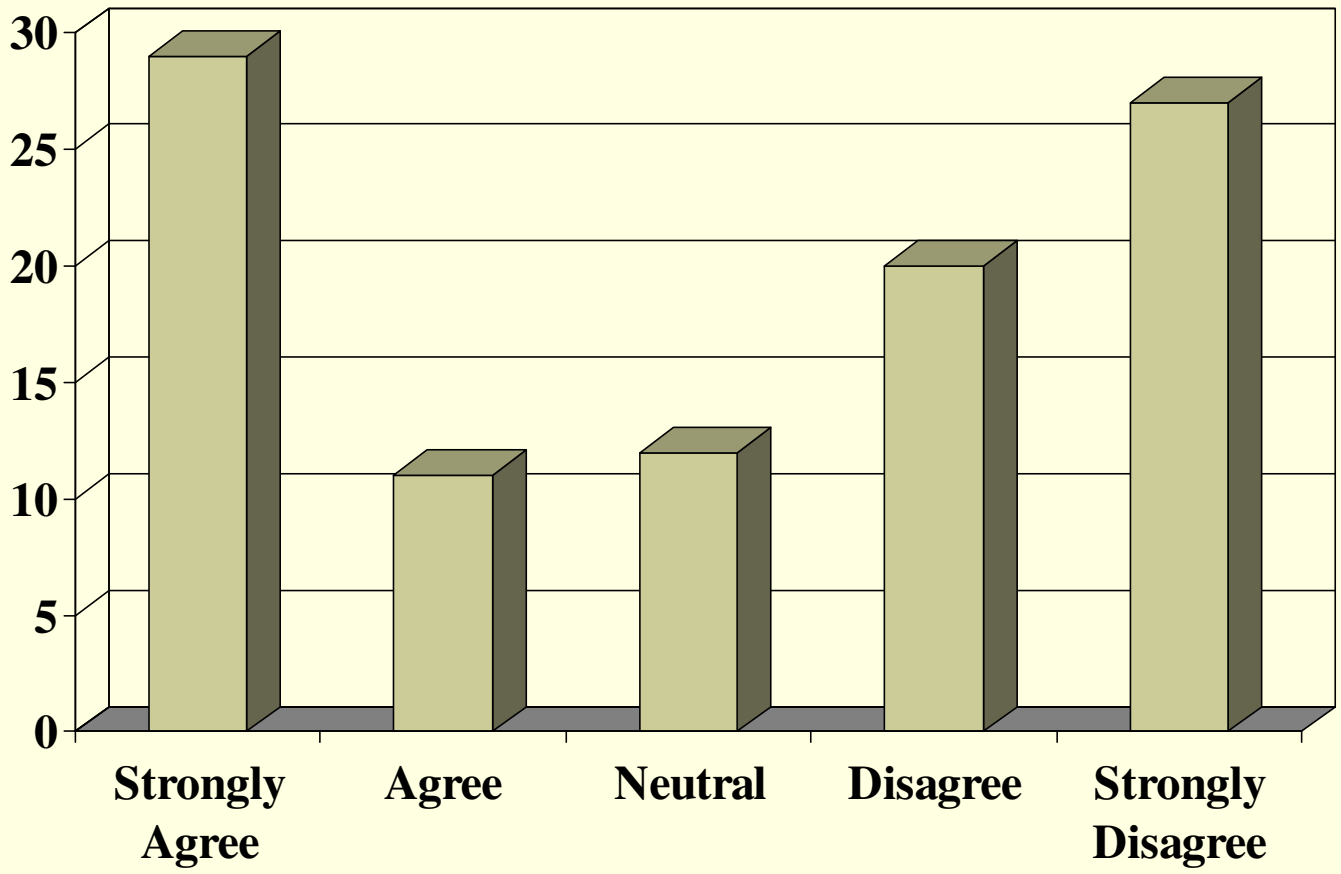
Community Forum: Definition of "Mental Disorder"

Community Forum participants were evenly split – with strong opinions – when asked whether they agree or disagree with the following statement:

The definition of "mental disorder" in Washington State is too broad, resulting in detention and civil commitment of people who are not best served in an inpatient psychiatric setting.

*** Caveat: Context of question related to people who have specific disorders such as developmental disabilities, TBI or dementia may not have been fully understood. However, result is consistent with fact that "lack of specialized community services for special populations" was ranked 6th of 10 factors affecting the use of civil commitment.*

Community Forum: Definition of "Mental Disorder"



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Major Finding #4

Washington's definition of "gravely disabled" is broader than many other states' definitions.

- About half the states, like Washington, permit civil commitment when a person's essential human needs such as food, shelter, and protection in the community, are met.
- Of those states, many require that a person be unable to make an informed judgment about their own treatment needs.

Analysis Regarding Definition of "Gravely Disabled"

Strengths:

- Permits civil commitment of people who are experiencing a severe deterioration in functioning without requiring that they become dangerous to themselves or others
- Permits flexibility:

  "A common theme here is that even though the grounds for commitment are present, a DMHP does not necessarily need to detain. However, if you shrink the available grounds for commitment, a DMHP will be unable to detain, even when the need to detain is great."

Analysis Regarding Definition of "Gravely Disabled"

Challenges:

- About 62 percent of people detained in FY2006 were considered to be "gravely disabled" (although many may also have met other commitment criteria)

Options for Reform:

- Modify Part B to permit commitment only when:
  - The person is unable to make their own informed judgment about treatment (Arizona)
  - If the person's deterioration is likely to result in the person requiring involuntary hospitalization based on prior experience (Oregon)

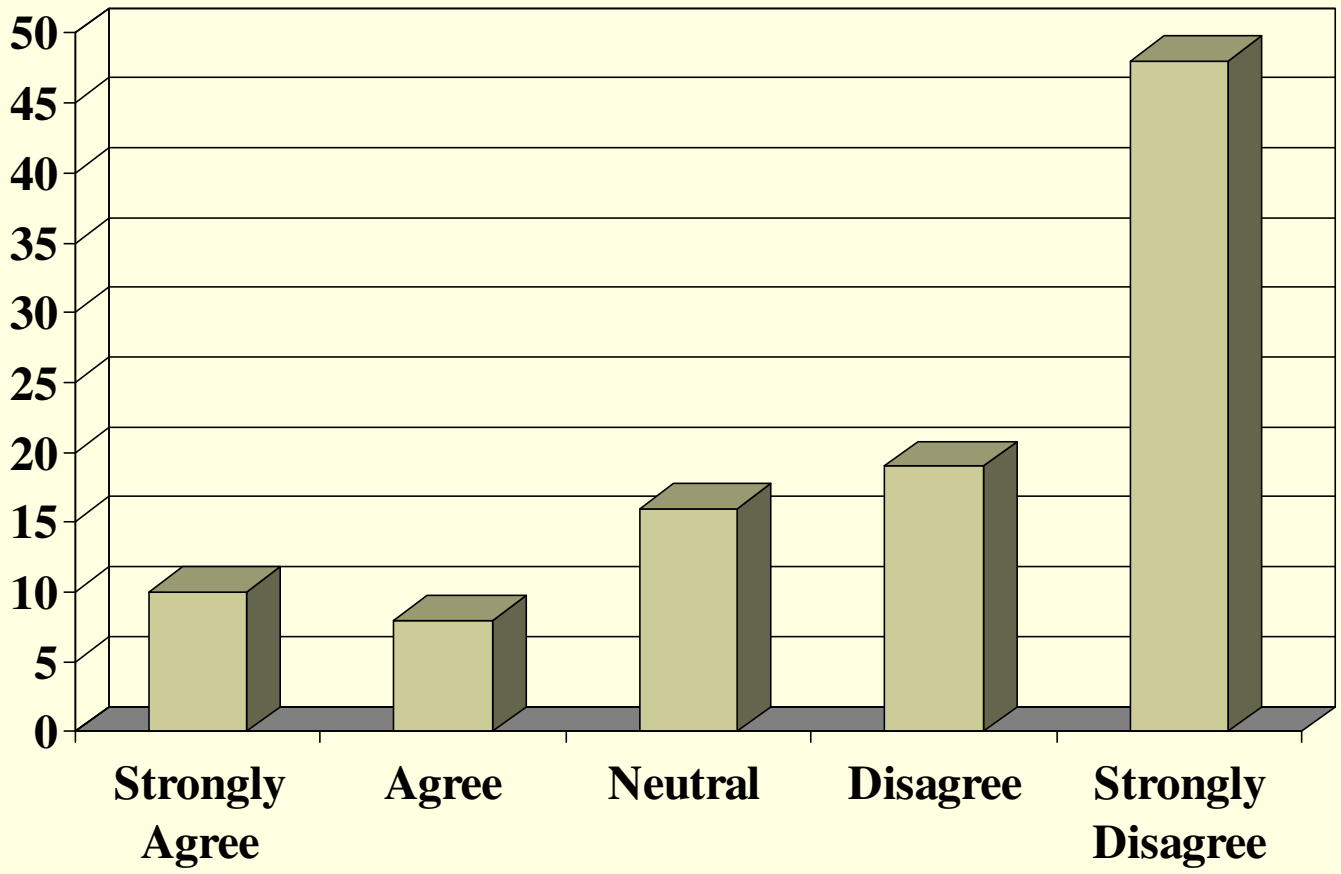
Community Forum: Definition of "Gravely Disabled"

Almost half (48%) of Community Forum participants strongly disagreed with the following statement:

In my opinion, the definition of "gravely disabled" in Washington State is too broad, resulting in the over-use of civil commitment and inpatient services.

(67% either strongly disagreed or disagreed with the statement)

Community Forum: Definition of "Gravely Disabled"



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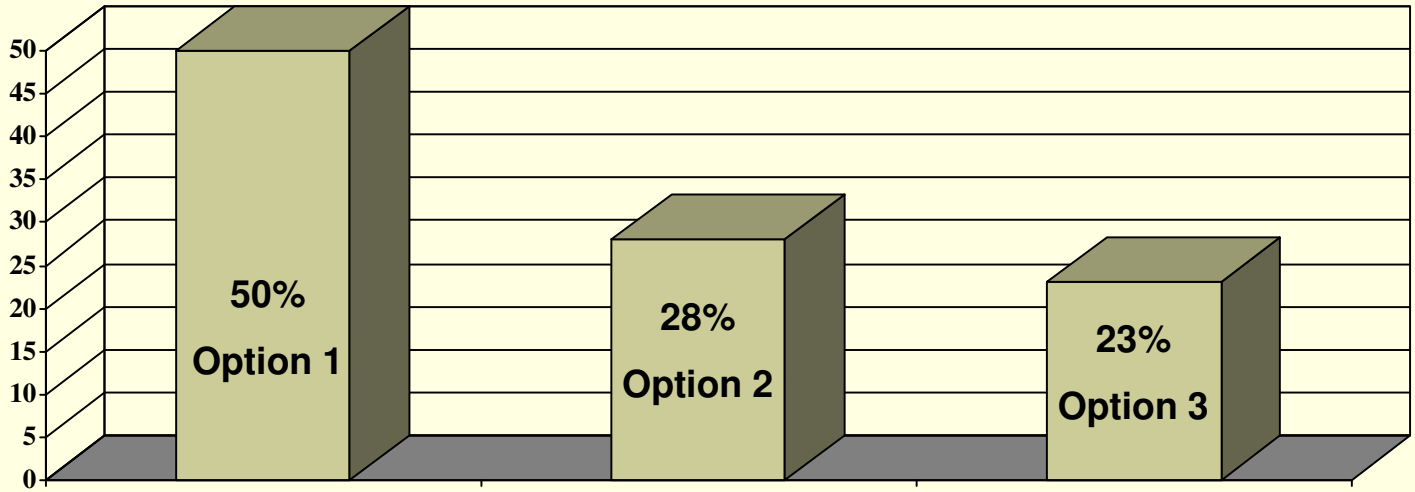
Major Finding #5

Most stakeholders participating in the STI process would support narrowing criteria for civil commitment, but most say they would support reforms only if needed community services and supports were in place first.

Community Forum: Support for ITA Reform



1. I would support narrowing criteria for civil commitment, but only if needed community services and resources were in place first.
2. I support narrowing criteria for civil commitment as a first step, with the belief that statutory change will motivate the state to create a more effective community-based, recovery-oriented delivery system.
3. I would not support narrowing criteria for civil commitment under any circumstances.

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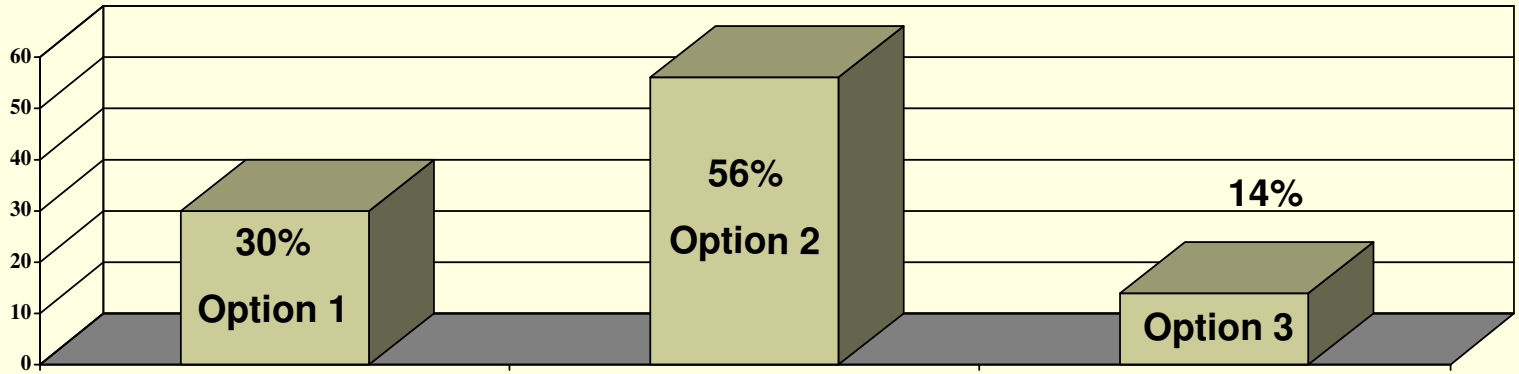
Major Finding #6

Parent-initiated treatment for minors, as provided at RCW 71.34.600 – 71.34.660, may address family and legislative concerns regarding the age of consent to mental health treatment in Washington State, but it is not often used, probably because:

- Parents are unaware of this option
- Perceived lack of clarity regarding due process procedures for minors who do not consent
- Concern regarding independent reviews of provider admission decisions and/or other reimbursement issues

Community Forum: Age of Consent and Parent-Initiated Treatment



1. Teenagers (ages 13-17) should be able to make their own decisions about mental health care and should be treated against their will only if they meet the same civil commitment criteria as adults.
2. Teenagers should be able to seek and receive both inpatient and outpatient mental health services without their parents' knowledge or permission, but they should not be able to refuse treatment that their parents and treatment providers feel they need.
3. Teenagers are not yet mature enough to make decisions about their own mental health care, and parent, in collaboration with clinicians and other treatment providers, should be the final decision-makers regarding treatment.

Recommendations for Next Steps

Several issues have been identified as requiring additional study by MHD:

- Accuracy of data regarding community and state hospital utilization, detentions, and civil commitments across RSNs
- Parent-initiated treatment
- Involuntary medications
- Use of advance directives

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Wrap Up

- General timeframes and plans for moving forward
- Future Meeting/s?
- Strengths and challenges of process to date
- What information will be helpful to keep people engaged?
- What process would be helpful to keep people engaged?
- Final comments regarding any of the projects

Additional Information

For further information on STI:

http://www1.dshs.wa.gov/Mentalhealth/STI.shtml

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